

The Modern Hospital

SEPTEMBER 1957

HOSPITALS PREPARE FOR ASIAN INFLUENZA

Report on nationwide organization plans—Wire From Washington
Medical coordinator describes hospital problems—page 148

WHY MEDICAL STUDENTS CHOOSE INTERNSHIPS

Report of a new study shows the reasons—page 61

SOME WAYS TO SAVE TIME ON NURSING FLOORS

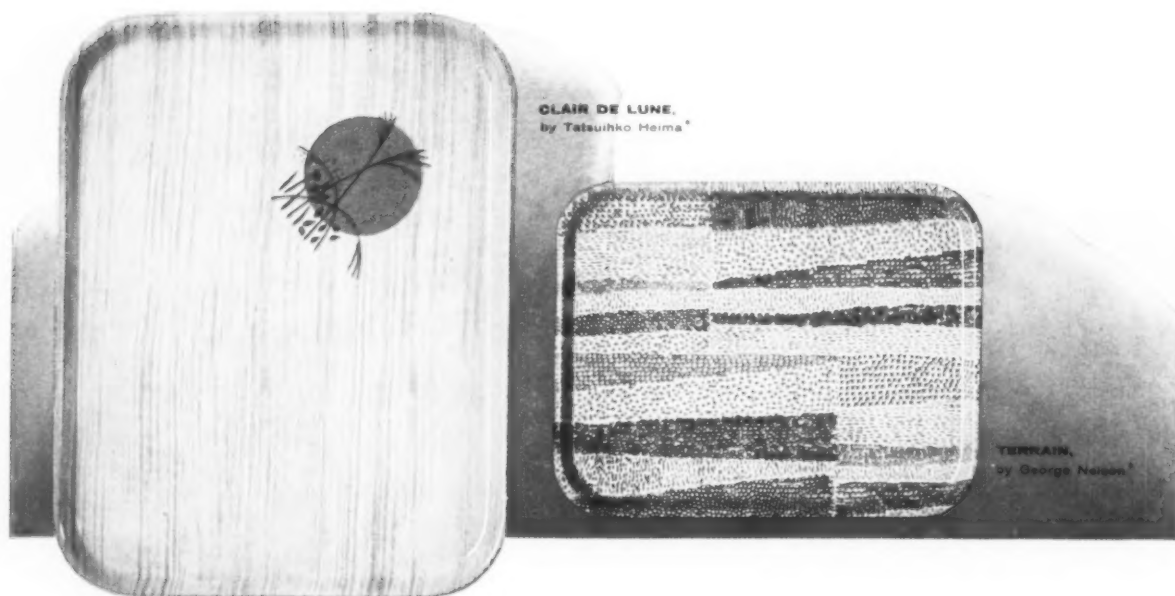
Round table discussion of staffing problems—page 72
"Automat plan" puts supplies in one place—page 55

IT PAYS TO HAVE PURCHASING POLICIES

Checklist of what policies should cover—page 85



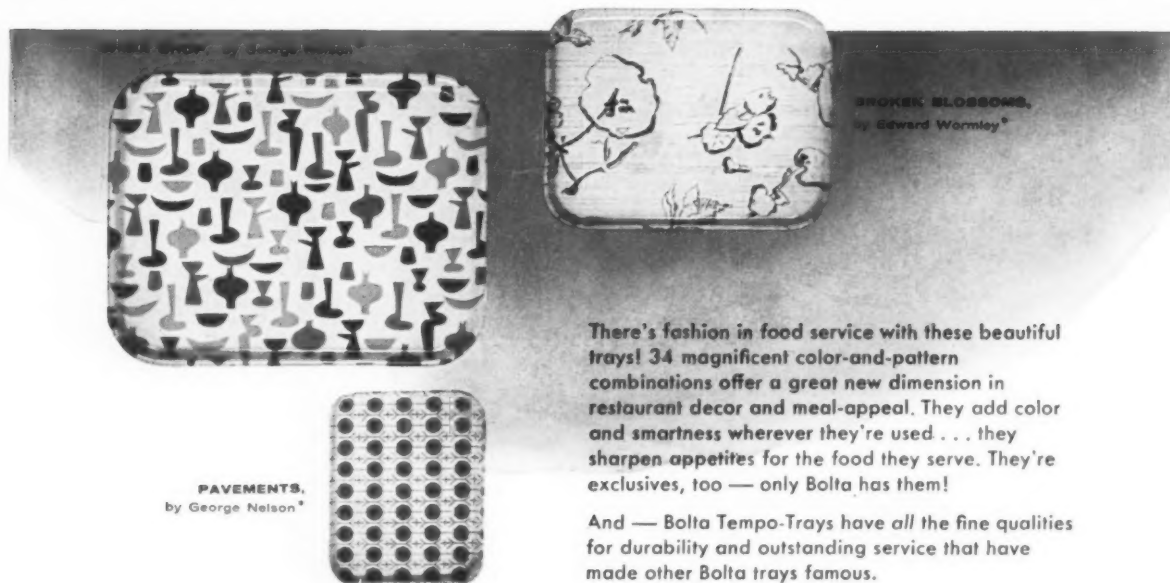
ARTIST'S RENDERING OF NEW BERWICK HOSPITAL, BERWICK, PA. (Page 55)



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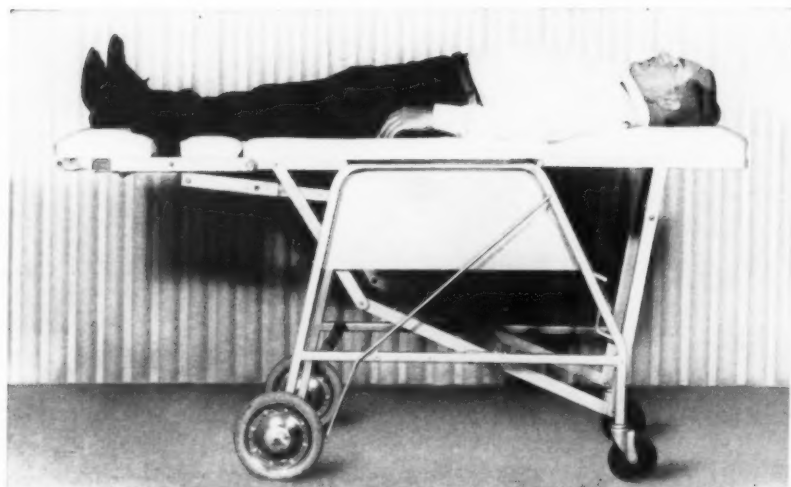


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The Modern Hospital

SEPTEMBER

1957

Artist's Rendering of New Berwick Hospital, Berwick, Pa. Cover
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Vol. 89, No. 3, September 1957

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AMONG THE AUTHORS

The pharmacy department can successfully operate the central sterile supply, if there is cooperation between nursing and pharmacy departments and if the physical facilities necessary for the program are available. So say **Milton W. Skolaut** and **Janet L. Fitzwater, R.N.**, and they can point to the satisfactory operation of such an arrangement to back up their statement. On page 98, the authors describe how the pharmacy-operated sterile supply program is carried out at the Clinical Center, National Institutes of Health, Bethesda, Md. Mr. Skolaut is chief of the Center's pharmacy department, and Miss Fitzwater is chief of the surgical nursing service, nursing department. Mr. Skolaut received his first experience with a pharmacy-sterile supply combination service in 1941 as a pharmacy intern at Johns Hopkins Hospital, Baltimore. Subsequently he was an instructor in pharmacy at the University of Maryland and chief pharmacist of the university's hospital. He entered the U.S. Public Health Service in 1949. Before joining the staff of the Clinical Center when it opened in 1953, Miss Fitzwater was operating room supervisor at the Providence Hospital division of Catholic University and at Doctors Hospital, Washington, D.C. She is a graduate of Providence Hospital School of Nursing and has her B.Sc. degree from Catholic University of America's school of nursing education.



Milton W. Skolaut Janet L. Fitzwater, R.N.

What is an administrative dietitian and what should her qualifications be? On page 110, **Dorothea Bartlett**, chief dietitian at Mary Hitchcock Memorial Hospital, Hanover, N.H., gives her answers to these questions. She also outlines the path a prospective administrative dietitian should travel to reach her goal. Miss Bartlett graduated from Connecticut College with a degree in home economics and received a master's degree in institutional management from Teachers College, Columbia University. Her first job was that of therapeutic dietitian, and later assistant administrative dietitian, at Mary Hitchcock Memorial. She then served one year as dietitian in a small New Hampshire hospital and five years at Mount Auburn Hospital, Cambridge, Mass., where she also directed a newly organized dietetic internship program. She returned to Mary Hitchcock Memorial eight years ago as chief dietitian.



Dorothea Bartlett

At Marion Memorial Hospital, Marion, Ill., nobody spends time bemoaning the fact that nurses are hard to find. Everyone's too busy carrying out successful plans for the hospital to "grow its own," **Shirley Lindberg**, the administrator, explains in her article beginning on page 81. The first such program is a scholarship fund, through which local girls are given financial help for nurse's training. At the time of graduation, the students offer their services to the Marion hospital for 18 months. The second recruitment plan involves a group of high school girls, who are taught various hospital procedures, dressed in yellow pinafores, and dubbed "Buttercups." Mrs. Lindberg, who has held several hospital administrative posts, is a trustee of the Illinois Hospital Association and vice president of the Illinois Tenth District Hospital Association.



Shirley Lindberg, R.N.

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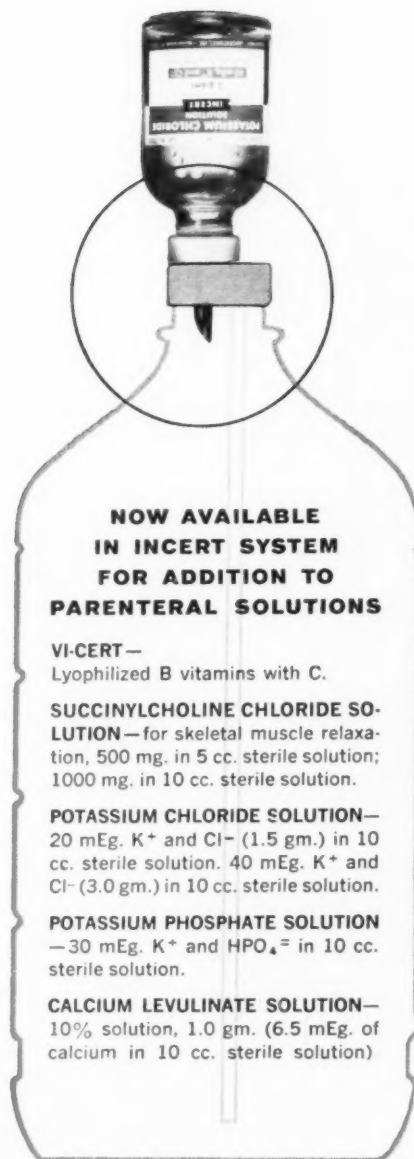
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READER OPINION

Where Does Nurse Education Really Belong?

Sirs:

In his article in the July issue of *The MODERN HOSPITAL*, "The Five Sides of the Nursing Problem," Dr. Hale plays fairer than he has ever done before but his philosophy still shows through. It's too bad he can't examine that more critically.

The Hale school of thought holds that nursing education belongs to the

hospital—and at the hospital's price. It must be related to hospital needs and trimmed according to hospital budgets, regardless of the fact that nursing students are preparing for lifelong careers. In my book that disregard of the youngsters' futures is amoral, if not immoral.

The Hale school recognizes that nurses are working elsewhere, but it

does not recognize that *nursing* exists outside of the hospital. The only way to improve patient care is through more nurses. The only admission of administrative failure is that the pay isn't adequate, but "if nurses can be patient" (he doesn't say for how long) that trouble will be adjusted.

The Hale school simply cannot recognize that nursing has become an essential community service, and thus must gear its education to broader lines than ever before. The only way we can learn where nursing education belongs is by the trial and error method that is now going on. As it always has done in human progress, the pendulum will steady at the point weighted by the heaviest evidence.

I do wish nursing educators were more articulate about the trial and error projects of today. An official of the Illinois Hospital Association asked the National League for Nursing, "What are the objectives of nursing? If you have them we hospital people do not know them." I want to ask, "What are the hospitals' objectives? If you have them we nurses do not know them." The same question can be put to medicine. The point is that we're all in a high state of transition, the aftermath of the greatest half century of health change in all history, and the precursor of greater things to come.

Dr. Hale is so right when he calls for a long-range study of the whole matter by a commission. He is only half right when he states that the payroll is the largest single item of the budget. The other half is that this is true of *every* service agency—in education, health, library, and whatnot. He is half right when he scolds about teachers (nursing) being away from the actualities of patient care. Isn't that true of teachers everywhere?

His claim that increased pay for nurses means increased costs to the patient can't be answered until the day a commission is free enough and objective enough to weigh the hospital dollar accurately. The doctors won't like the answers.

Janet M. Geister, R.N.
Chicago

Right Road—Wrong Mud

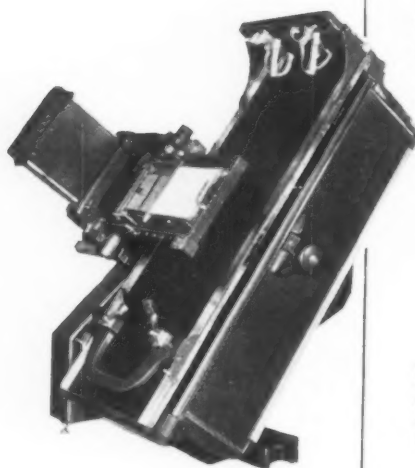
Sirs:

I should like to comment on the editorial "Muddy Road Ahead" which appeared in the June issue of *The MODERN HOSPITAL*.

Apparently there was some misun-

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derstanding on the part of the writer about the action taken and reported in *Chart* regarding Springfield Memorial Hospital. That negotiations were under way between I.N.A. and the Memorial Hospital was not the case. The action taken by the hospital administrator was unilateral and in the June issue of *Chart* "Sounding Board" I quote from his letter. . . . "I believe that all registered nurses should belong to their own professional organization and have always encouraged our nurses at Memorial Hospital to be active members. My feeling for the I.N.A.

is such that even though I do not completely agree with all its programs, we are planning to deduct \$10 a month from nurses who do not join by June 1, 1957." From this you can see that management justly takes the full credit for establishing this membership policy.

Your editorial infers that the nursing organizations have taken a position on compulsory membership. It is our conviction that every nurse should be a member of her professional organization in order to exert her influence on the activities which shape the future

of nursing practice and influence the welfare of the individual. However, the organization has never taken a position on compulsory membership. Where the governing body of an institution or agency feels that participation in the organization is important to the growth and development of the nurse and has set membership as a criterion for advancement or merit increase, the organization has not disapproved.

However, the issue that "muddies the road ahead" is not that of compulsory membership but the right of the nurse to have a legitimate voice in determining her own employment conditions. It is the resistance of hospitals to meet with nurses in a democratic negotiation process that has aggravated the issue.

Your editorial states that "nurses are certainly entitled to better working conditions than they have often earned in hospitals." It is through the economic security program of their professional organization that the effort is being exerted to correct this situation. Through their association the nurses have voluntarily relinquished the right to strike or to indulge in other practices which might endanger the welfare of the patient.

However, the nurses are increasingly determined to make their voice heard in the establishment of policies that affect them and we hope that hospital administrators will not indulge in certain discrediting tactics that will subjugate this right. It behooves all who are concerned with the welfare of the patient to become realistically aware of their moral responsibility for respecting the human dignity and rights of those ministering to him. We have arrived at a new era of employer-employee relationships.

Anne Zimmerman
Executive Secretary

Illinois Nurses Association
Chicago

The impression that the association, and not the hospital alone, initiated the salary differential for member nurses came from the report in the April issue of CHART, referring to a meeting of Memorial Hospital nurses and "members of the I.N.A. economic security staff." The impression that this meeting was not unrelated to the differential pay scale reported in the next paragraph of the article in April CHART was shared by a number of CHART readers.—Ed.



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1. Bacala, J.C.: The Use of the Systemic Hemostat, Carbazochrome Salicylate, West J. Surg. 64:88 (1956).

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ROVING REPORTER

Tri-Cornered Hospital Opens

Three long rectangles form a new triangular hospital, one of the first in northern California specifically designed and equipped for physical therapy.

The 56 bed hospital, named Marin Convalescent and Rehabilitation Hospital, will treat patients suffering from physical disabilities, accidents, heart disorders and strokes, postpolio patients, paraplegics, and arthritis victims.

The three main buildings are connected by triangular tie-ins at each of the three corners, giving the hospital its triangular shape. The end rooms provide the kitchen area, solarium and physical therapy treatment and workroom. In the center of the triangular area is a courtyard and sun area, accessible from all three wings, for convalescent patients.

Even the swimming pool, located on the inner patio of the hospital, is triangular in shape. The pool is equipped for various types of therapy, is heated, and completely enclosed. Sections of glass over the pool and along one side let in sunlight.

The home is under the direct supervision of owner-administrator William Pouloupoulos, chief physical therapist of the 100 bed Marin General Hospital, San Rafael. The staff will include two affiliated physical therapists, an occupational therapist, 15 nurses, orderlies and aides, a dietitian, business manager, and maintenance personnel.

The new hospital, representing an investment of more than \$350,000, is located on a hill on the Tiburon Peninsula near San Francisco, overlooking the Golden Gate bridge to the south, Mount Tamalpais to the west, and the East Bay to the north.

A. Jane Duncombe of Mill Valley, Calif., a former student of Frank Lloyd Wright, designed the structure.

Music Soothes in the Surgery

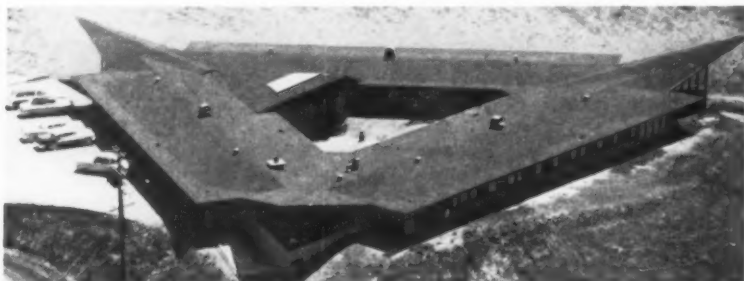
Selected surgical patients at Mary Hitchcock Hospital, Hanover, N.H., are being administered music along with anesthesia. This innovation is based upon studies which have found that suitable music can be an aid in quieting surgical patients, thereby reducing the usual requirement for sedative drugs.

Semiclassical music, performed on stringed instruments, is played before and during administration of an anesthetic in the induction and operating rooms, as well as in the recovery room.

Plans for using music at Hitchcock Hospital were made by Dr. Richard H. Barrett, head of the anesthesiology department, as early as 1948. In 1952, when a new wing was built, electrical conduits were installed for later wiring. The music comes through loudspeakers or head phones, depending upon which the doctors may choose. Selections are from a list drawn up from research on audience reactions.

Even a listener who may not like semiclassical music has been found to catnap, rather than resist it, when it is played. In general, drums, some woodwinds, and brasses are avoided. A main emphasis has been upon high quality tone, without distortion.

Patient reaction is being studied with the expectation that the limited research now available on the use of music as a technic of the anesthesiologist will be increased.—*From TIDINGS, publication of the New Hampshire-Vermont Hospitalization and Physician Service (Blue Cross-Blue Shield), Concord, N.H.*

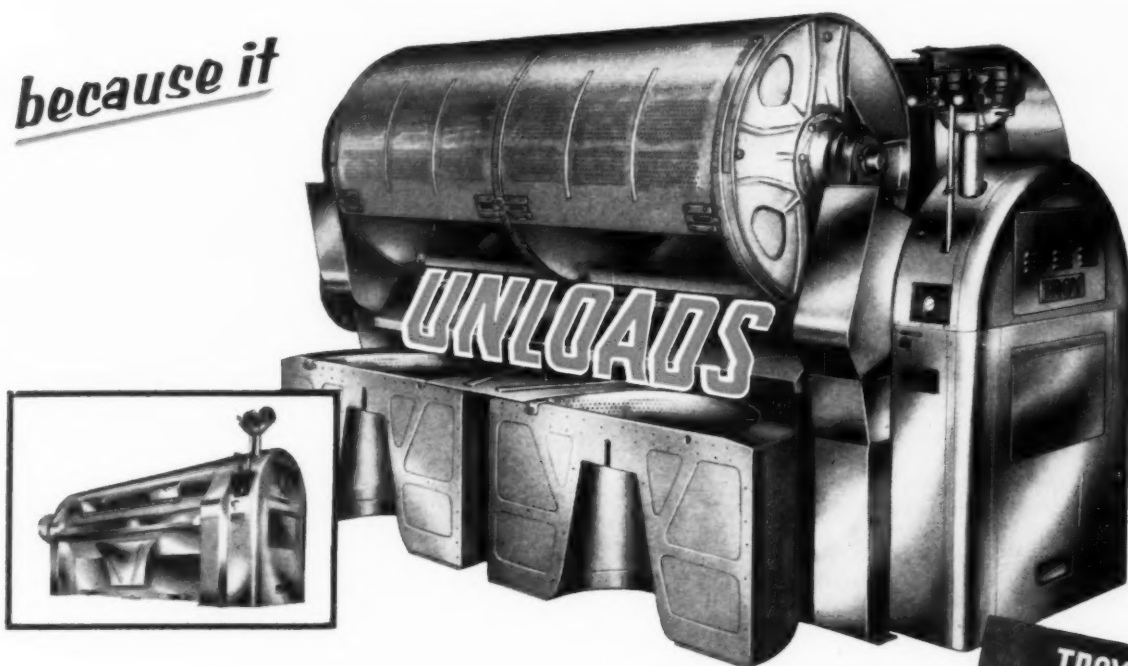


Triangular tie-ins at each of the three corners connect the three main buildings of this new 56 bed hospital which is designed for rehabilitation.

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Public Relations

A True Public Relations Program Means You Promise to Listen as Well as Tell

By GORDON DAVIS

IF ALL you are trying to do with public relations is to make people appreciate how good you are, that isn't a public relations program; it's a soft soap campaign.

Well, maybe that's a little severe. You may be quite justified in claiming public credit, but the true meaning of public relations is eluding you if you assume that its only function is to propagandize your good works.



Gordon Davis

Public relations is the public looking over your shoulder, commenting, questioning, criticizing and, on occasion, applauding if you deserve it. If you can't stand to have your every move scrutinized, you should not have a public relations program and you probably should have nothing to do with the administration of any public institution such as a hospital.

For this is the trend of American democracy: No one responsible for employing, directing or serving masses of the people can live in an ivory tower. Sooner or later the public moves in on the cloistered one and, if he still resists, there arises a clamor that bestirs the eager politicians and brings public compulsion.

The only other alternative is to languish in obscurity and ultimately to wither from neglect. You've seen this happen to many a management which considered that it was sufficient unto itself.

When you take a true public relations program into your institution or organization, you promise to listen to the people as well as to tell them. By "the people" we mean all the groups with whom you deal, from employees to the most woebegone derelicts in your charity wards.

Not only do you listen, but you act in response to what you hear. Some of your most cherished notions may get liquidated in this process, and you must be willing to let them go.

But if you are doing a good job, if your motives are worthy and your conscience is clear, you will be rewarded by unshakable public support and you will be amazed by the way in which this lightens your administrative burdens.

Public relations is your organized means of determining that you are correctly diagnosing public attitudes, that you have adequate information on which to base administrative decisions. It is also the public's viewing glass, the window through which the sidewalk superintendents can marvel at the efficacy with which you do your job.

We've said it before: Public relations cannot make you either be or appear to be righteous if the facts are otherwise. When you are striving to be right, however, public relations deepens and extends your channels of communication with your fellow human beings so that they may know of your sincerity and so that you may learn how to serve them better. If we believe in democracy—indeed, if we believe in humanity itself—this cannot be other than good.

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shaft of handle, where thumb naturally falls as you guide Foodveyor in reverse.

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* Self-propelling "Touch-n-Go" power device has foreign and U. S. patents pending.



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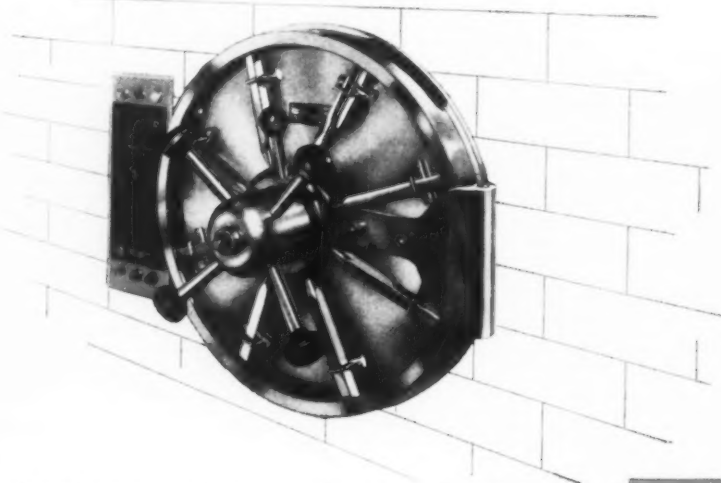
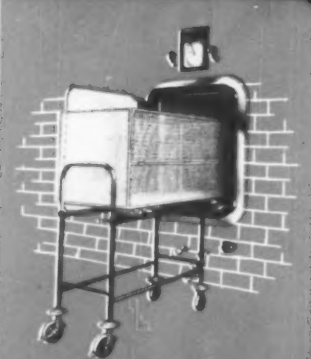
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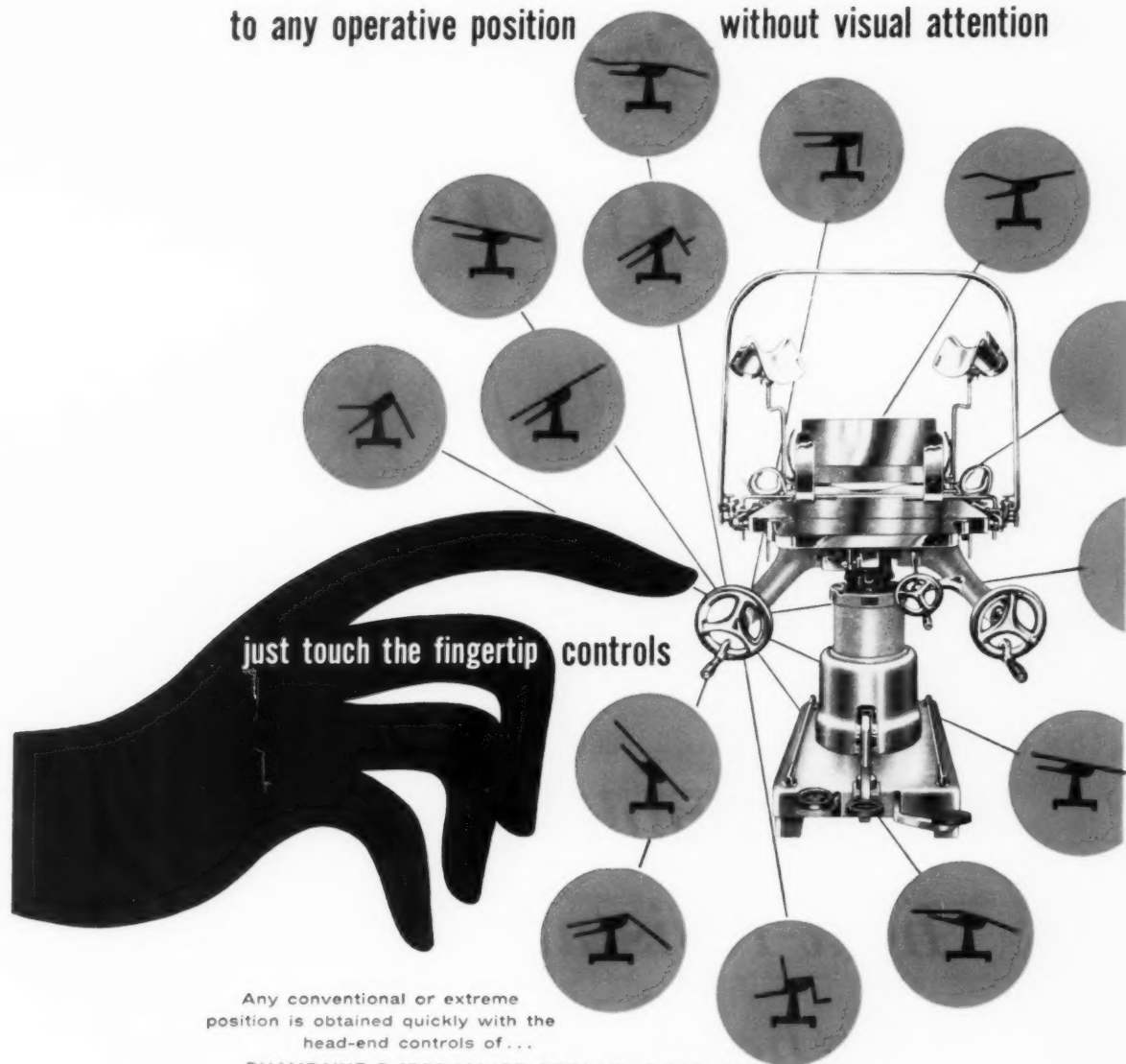
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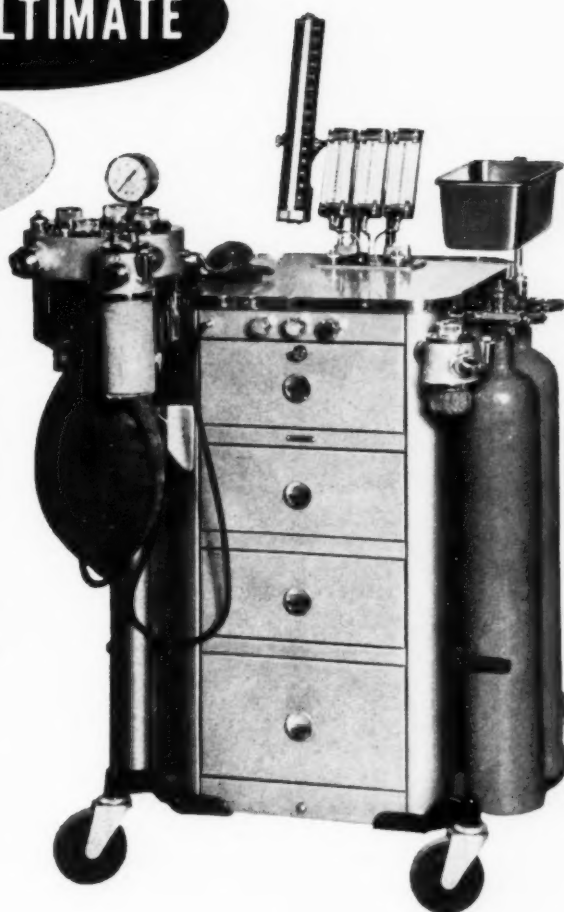
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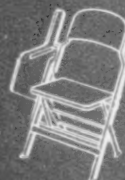


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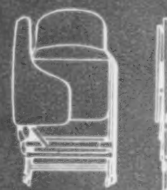
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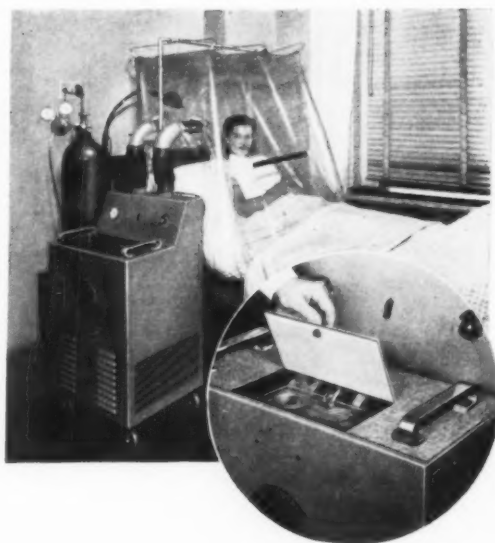
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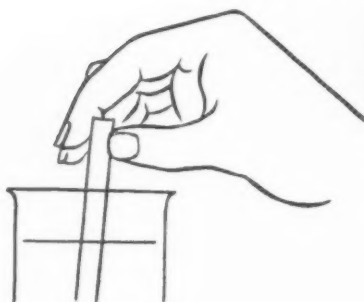
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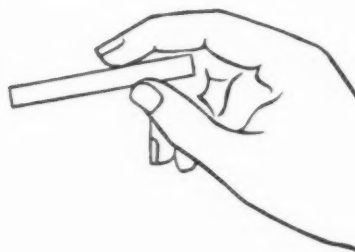
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Standard vs Disposable Unit Enema: Rainier,
W. G. and Lee, B., *Hospitals*, 31:50, January 1, 1957.

(1) Swinton, N.W., *Surg. Clin. No. Am.*, 35:833, 1953

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World leader in antibiotic development and production

LAKESED Stainless Steel

Utility Carts • Tray Trucks • Lab Carts

Pay Their Way Saving Minutes Each Day!

... in Food Service, Tray Service... as Dressing Carts, Medicine Carts



UTILITY CARTS FOR EVERY HOSPITAL NEED!

Look at the choice you have for dressing carts, medicine carts, mobile equipment and instrument stands... for serving and clearing carts in kitchen and cafeteria! All are outstanding values: made of easy-to-clean stainless steel... designed for smooth, silent handling... built for years of dependable service. And even if you save only minutes a day with a LAKESED utility cart, it pays for itself in a year!

SPECIFICATIONS	311	322	411	422	444
Size of Shelves	15 1/2 x 24"	17 1/2 x 27"	15 1/2 x 24"	17 1/2 x 27"	21 x 35"
Clearance between Shelves	11 1/4"	12 1/4"	12"	12"	13 1/4"
Stainless Steel in Top	22 gage	20 gage	20 gage	20 gage	20 gage
Stainless Steel in Uprights	20 gage	20 gage	16 gage	16 gage	16 gage
Carrying Capacity	200 lbs.	200 lbs.	400 lbs.	400 lbs.	500 lbs.
Standard Bumpers	—	—	—	—	—
Diameter of Caster Wheels	3"	3"	4"	4"	5"
Shipping Weight	28 lbs.	33 lbs.	37 lbs.	45 lbs.	72 lbs.
PRICE (FOB Milwaukee, Wis.)	\$32.95	\$39.95	\$51.00	\$56.75	\$98.25

TRAY TRUCKS "AUTOMATE" FOOD SERVICE

LABORATORY CART SAVES BREAKAGE

Here's the answer to

- fast, efficient tray service to rooms...
- portable shelf space in kitchens...
- holding servings prepared in advance...
- movable shelves for walk-in refrigerators
- many other uses!



With All Shelf Edges Down:	445	433	449	480	482	484
With 3 Edges Up, 1 Down:	448	448	451	481	483	485
Size of Shelves	21x35"	21x35"	21x35"	21x50"	21x50"	21x50"
Overall Height	45 1/2"	50 1/4"	54 1/4"	45 1/2"	50 1/4"	54 1/4"
Approx. Clearance between Shelves	11 1/4"	7 1/4"	5 1/4"	11 1/4"	7 1/4"	5 1/4"
Stainless Steel in Top	20 gage	20 gage	20 gage	20 gage	20 gage	20 gage
Stainless Steel in Uprights	16 gage	16 gage	16 gage	16 gage	16 gage	16 gage
Carrying Capacity	500 lbs.	500 lbs.	500 lbs.	500 lbs.	500 lbs.	500 lbs.
Wheels: 2 swivel, 2 fixed (STD. Equip.)	5" Dia.	5" Dia.	5" Dia.	5" Dia.	5" Dia.	5" Dia.
Standard Bumper Equipment	Strip and Handle	Strip and Handle	Strip and Handle	Strip and Handle	Strip and Handle	Strip and Handle
Shipping Weight	81 lbs.	102 lbs.	135 lbs.	122 lbs.	153 lbs.	190 lbs.
PRICE (FOB Milwaukee, Wis.)	\$114.25	\$135.00	\$172.00	\$162.00	\$210.00	\$260.00

OPTIONAL Equipment at extra cost	Channel bumper, all swivel caster wheels, 8" swivel and/or fixed wheels.	Channel bumper, all swivel caster wheels, 8" swivel and/or fixed wheels.
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Especially designed for glassware, bottles, laboratory instruments and supplies. Has 2" guard rail on all shelf edges. All other specifications same as Model 422 above. Shipping weight 49 1/2 lbs.

Model 526 Laboratory Cart
Price (FOB Milwaukee) \$64.50

LIGHTWEIGHT, LOW-COST TUBULAR CARTS



Model 655 (left) 15 1/2 x 24" shelves with 2 casters, 2 8" wheels - - - \$29.95

Model 688 (right) 15 1/2 x 24" shelves - - - \$26.95

UTILITY PANS Model 111... for 311, 411, 444, 459, 655, 688 carts. 21 x 14 1/2 x 5" **\$12.60**
Model 122 for 322, 422, 526 carts. 24 x 16 1/4 x 5" **\$14.70**

WASTE BOXES Model 131... for 311, 411 carts. 14 1/2 x 12 x 3 1/4" **\$12.60**
Model 132 for 322, 422, 526 carts. 16 1/8 x 12 x 3 1/4" **\$13.40**

UTILITY BOXES Model 141... for 311, 411 carts. 14 1/2 x 6 x 5 1/4" **\$9.50**
Model 142 for 322, 422, 526 carts. 16 1/8 x 6 x 5 1/4" **\$10.50**

LAKESED MFG. INC.

America's Leading Manufacturer of Stainless Steel Carts and Trucks

Prices FOB Milwaukee, slightly higher in West. Subject to change.

1976 SOUTH ALLIS STREET
MILWAUKEE 7, WISCONSIN

KYS-ITE® Color-Craft Trays

*... Gay Colors
whet the appetite*

KYS-ITE Color-Craft molded plastic trays brighten mealtimes in restaurants and institutions. The beautiful patterns and colors are carried over both sides of the trays, and the edges are smooth and closed. The use of a variety of colors has proved popular, particularly in cafeterias, or you can order a single color to harmonize with the décor of your restaurant.

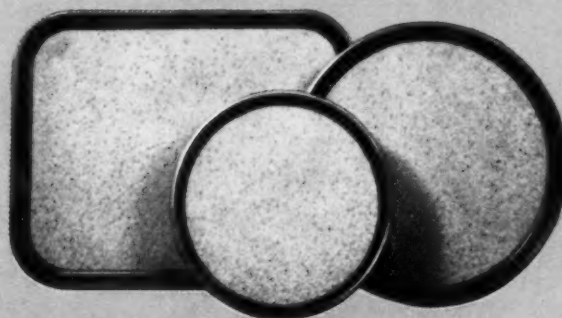
- ★ Choice of two handsome patterns, each available in four colors.
- ★ Extra strong, almost indestructible.
- ★ Stain-resistant, non-corroding, easy to clean.
- ★ Impervious to boiling and to mild acids or alkalis. Guaranteed not to warp.
- ★ Lightweight and quiet in use.



**a complete line of trays
to fill every need**



REGULAR KYS-ITE® SERVING TRAYS
for durability and economy. 10 sizes
available in red, brown and rust.



KYS-ITE® CORK-SURFACED TRAYS
for non-skid, safety service. 5 sizes
available in red and brown.

Be Wise-Buy



MAIL THIS COUPON

Keyes Fibre Company, Waterville, Maine

Please send further information on KYS-ITE, KYS-ITE Cork-Surfaced and KYS-ITE Color-Craft Trays.

NAME.....

NAME OF FIRM.....

ADDRESS.....

.....



4 PIONEER Rollprufs® Cover All Surgical Requirements

Tissue-thin White
Latex with Flat
Color Banded
Beadless Wrists
and easy-to-sort
Multi-Size
Markings in color.

RP-158



Non-slip textured
area on fingers
and palm of Brown
Latex with Flat
Color Banded
Beadless Wrists.

RP-169R



Tissue-thin Color
Banded Brown
Latex with Flat
Beadless Wrists
and easy-to-sort
Multi-Size
Markings in color.

RP-168



Green Neoprene
with Flat Banded
Beadless Wrists
for those allergic
to natural latex
surgical gloves.

75 LW



Color Identified to Cut Glove Sorting Time
Compounded to Withstand 10 to 20 Sterilizations
Quality-Made and Individually Inspected

the **PIONEER** Rubber Company
350 Tiffin Road, Willard, Ohio

Pioneers in Surgical Hand Protection
for over 35 Years


TO A HOSPITAL ADMINISTRATOR WHO KNOWS The Importance of Being Human:

Who could know better than you the effect of warm, kindly, human feeling for your patients? Works wonders, doesn't it? And somewhat discouraging to consider the distance today's larger, better facilities and new duties have put between most administrators and the patients! Fortunately, good public relations can help bridge the gap. The Hollister *Inscribed* Birth Certificate at right, for example, brings the administrator closer to new parents, builds good will.



Your presentation of the strikingly beautiful, heirloom quality Hollister Certificate is a token of friendliness parents don't forget. Each Certificate is a work of art — LithoGraved® on diploma parchment. Yet the cost is low. Request FREE '57 Portfolio with the new *ribboned* samples.

FRANKLIN C. HOLLISTER CO., 833 N. Orleans St., Chicago 10, Ill.

 **HOLLISTER** *Inscribed* Birth Certificates



Only \$3.50 brings you the Bed Sign Demonstration Kit, including this 4-slot Sign and sample reminders.

Which of these bed sign reminders are needed most often in your hospital?

Those Hollister Reminders below are among the ones ordered most often by hospitals using Hollister Bed Signs. Look them over. All are clearly printed on plastic coated, durable card stock in a variety of colors. The beautiful Hollister Bed Sign (above) and Wall Rack (at

right, below) complete the system. Over 100 Reminders (shown actual size at right), and a wide variety of Bed Signs, Racks and Room Warning Signs are described in a colorful new 16-page book, *Beautiful Bed Signs*—yours FREE for the asking. Send for it.

TITLE	CARD COLOR	NUMBER	TITLE	CARD COLOR	NUMBER	TITLE	CARD COLOR	NUMBER
Absolute Rest	red	8502	Feed Patient	green	8570	O. R. in Morning	green	8556
Bathroom Privileges	green	8567	Flat in Bed	red	8588	Pre-operative	green	8557
Bed Bath	gray	8582	Force Fluids	yellow	8522	Radium	blue	8543
Bed Patient	gray	8581	For Surgery	green	8565	Restrict Fluids	yellow	8524
Bed Rest	gray	8572	Fractional Urine	yellow	8522	Save All Urine	yellow	8526
BMR	green	8550	Hard of Hearing	yellow	8537	Save Sputum	yellow	8554
BMR in Morning	green	8551	Hold Breakfast	red	8505	Specimen	yellow	8529
BP Every Hour	yellow	8538	Holy Communion	gray	8575	Save Stool Specimen	yellow	8523
Clinitest AM PM	yellow	8521	Ice Chips Only	buff	8591	Save Urine Specimen	yellow	8523
Clinitest Every	yellow	8530	Intake and Output	yellow	8523	Side Rails	gray	8580
Specimen	yellow	8530	Isolation	red	8506	Special Diet	green	8559
Clinitest 30 min. A.C.	yellow	8532	Keep Bed Flat	green	8872	Special Tests	green	8560
Complete Bed Rest	gray	8584	Keep Flat	red	8517	Stool and Needle	red	8807
Delay Tray	gray	8574	Keep Restrained	red	8803	Precaution	red	8807
Do Not Change	red	8812	Liquids Only	buff	8592	Strain All Urine	yellow	8533
Position of Bed	red	8802	No Breakfast	red	8507	Strict Isolation	red	8516
Do Not Disturb	red	8552	No Cigarettes or	red	8804	To Laboratory	green	8877
Do Not Disturb—BMR	green	8552	Matches at Bed Side	red	8596	To X-Ray	green	8564
Do Not Disturb—EKG	green	8553	No Fluids	buff	8518	24 Hour Sputum	yellow	8856
EKG in Morning	green	8554	No Smoking	red	8515	24 Hour Urine	yellow	8531
Encourage Fluids	yellow	8534	No Smoking—Oxygen	red	8514	Specimen	yellow	8566
Family Only	red	8504	No Visitors	red	8509	Up in Chair	green	8544
Fasting Blood Work	red	8589	Nothing By Mouth	red	8509	X-Ray Treatment	blue	8544

Need a supply now? Order by number.

If your staff is now enjoying the convenience of Hollister Bed Signs, you may need additional Reminder Cards. And you may be ready for the larger 18-peg Rack shown at right. Just jot down card titles, order numbers and quantities needed on your own stationery, or on a post card. If you haven't yet seen these

beautiful Bed Signs, order the \$3.50 Bed Sign Demonstration Kit (above), with Reminder Samples. Be sure to request the informative 16-page book, *Beautiful Bed Signs*, that pictures and describes this modern reminder system. We'll include, also, a price list showing discounts and FREE Wall Rack offer.



Big 18-peg Rack, only \$12.50. Hollister reminder cards, 50¢ per dozen, 30¢ per ½ dozen. Order by title and number, indicating quantities of each. Write for 16-page book, *Beautiful Bed Signs*. This colorful book pictures and explains the system, lists over 100 Reminder Card titles, shows prices and discounts.

HOLLISTER FRANKLIN C. HOLLISTER CO. 833 N. ORLEANS ST., CHICAGO 10, ILL.



*Another hospital
maintenance
problem solved...*

with PRO-TEX-MOR® DISPOSABLES



EXAMINATION TABLE
SHEETING

FLUSHABLE
BEDPAN COVERS



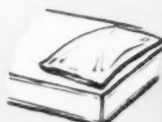
DISPOSABLE LINERS
FOR WASTE CAN



DISPOSABLE URINAL
COVERS



BEDSIDE
WASTE DISPOSER



VINYL MATTRESS AND
PILLOW COVERS



X-RAY FILM STORAGE
ENVELOPES



NIPPLE
COVERS



SYRINGE STERILIZER
BAGS



"DUET" SYRINGE
STERILIZER BAGS



EXAMINATION GOWN



CATHETER
STERILIZER BAGS

OTHER PRO-TEX-MOR DISPOSABLES

You get dollar-savings and better house-keeping when you go Pro-Tex-Mor... write for catalog of complete line



JUMBO WASTE CAN LINERS

Noise, unsightly littering of floors, and odors, the usual disadvantages of emptying cans direct, are eliminated... refuse collection becomes more efficient and economical when you use Pro-Tex-Mor Disposable Jumbo Waste Can Liners.

Filled liners are quickly tied closed, lifted out of cans, and carted off for disposal. Inside of cans are more sanitary, require less cleaning, last longer. More collection points can be covered in each load, cutting down the number of trips to the incinerator... saving time, requiring fewer employees.

SPECIFICATIONS:—Jumbo Liners are specially-treated Kraft bags, with tops long enough to tie securely; strong, waterproof seams; 25-30 gallon capacity.

**PRO-TEX-MOR MEDICAL DIVISION
CENTRAL STATES PAPER & BAG CO.**

5221 Natural Bridge • St. Louis 15, Mo.

SOLD EXCLUSIVELY THROUGH SURGICAL SUPPLY DEALERS



University of Mississippi Medical Center, Jackson, Mississippi. Malvaney, Naef, Overstreet, associated architects, Jackson; Landauer, Guerrero & Shafer, mechanical engineers, Dallas; Farnsworth & Chambers Construction Co., general contractor, Houston; H. W. Lancaster & Sons, mechanical contractors, Memphis.



One of five air conditioned student laboratories in this outstanding building. The provision of individual room control assures all-weather comfort and results in ideal conditions for student work and study.



Each of 577 underwindow air conditioning units is individually controlled by a Johnson Heating-Cooling Thermostat and Water Valve. Proper control safeguards patient health and comfort, saves valuable staff time.

Johnson Pneumatic System Provides Year 'Round Climate Control for Modern Medical Center

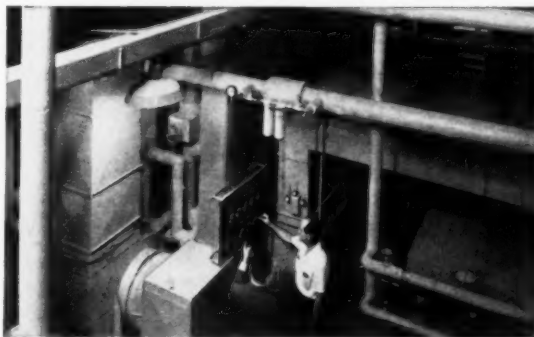
In the University of Mississippi Medical Center, year 'round air conditioning benefits patients, staff and students alike. Throughout this modern building... in operating rooms, special treatment rooms, laboratories, lecture rooms, nursing wings, offices and other areas... a specially designed Johnson Pneumatic Control System consistently maintains the exact temperatures and humidities required for every purpose.

To produce these ideal conditions, the control system directs the operation of a system of 577 under-window type air conditioning units in perimeter rooms of the building and 34 central fan air conditioning systems serving the interior areas. In addition, there are 14 Johnson controlled heating and ventilating systems to meet the specialized needs of the laundry, equipment rooms and pent-house.

Proper zoning adds to the flexibility and efficiency of the individual room control system. For example, the exterior rooms are zoned according to exposures. Each zone can be switched to heating or cooling operation, as required, independently of the other zones. Of special importance also is the control of humidities in operating rooms for protection against static electricity and the complete safety of Johnson pneumatic instruments.

Johnson Pneumatic Control provides the finest in modern temperature regulation for every type of air conditioning, heating and ventilating system. Its unmatched flexibility satisfies every control requirement simply and efficiently. The accurate trouble-free operation of a Johnson Pneumatic Control System can add substantially to your hospital's efficiency and keep your air conditioning, heating and ventilating costs at a minimum.

When you build or modernize, talk to your architect or engineer about the advantages of Johnson Pneumatic Control. Or call an engineer from a nearby Johnson branch. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.



Behind the scenes is this Johnson summer-winter changeover switchboard in one of the fan rooms. Pneumatic control systems not only meet every need in modern buildings, but are the simplest to operate and easiest, most economical to maintain.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885





Does OXYGEN THERAPY support itself in your hospital?

IF your present oxygen therapy is a liability, LINDE can help you make it self-supporting—even an asset. With more than 25 years of experience in the hospital field, LINDE has shown hundreds of hospitals how to bring paying efficiency to oxygen administration.

1. A LINDE specialist studies the conditions under which oxygen is administered in a hospital.
2. He makes recommendations for correcting any faulty practices that are found and assists in carrying out these recommendations.
3. He works with the business office to establish a system of charges for oxygen therapy that are fair to both the patient and the hospital.

To start the ball rolling in your hospital, just call your LINDE distributor, or write your nearest LINDE office.

L I N D E C O M P A N Y

Division of Union Carbide Corporation

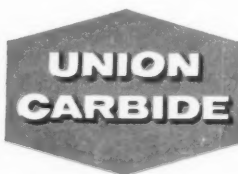
30 East 42nd Street, New York 17, New York

Offices in Other Principal Cities

In Canada: Linde Company, Division of Union Carbide Canada Limited.

The terms "Linde" and "Union Carbide" are registered trade-marks of Union Carbide Corporation.

Linde
TRADE MARK



Now ...a Better Technique
for Patient Utensils

the

UTENSIL WASHER -SANITIZER



The American Utensil Washer-Sanitizer provides efficient equipment to carry out an improved technique in preventing the transfer of communicable diseases among patients and hospital personnel. Convenient and automatic, it washes and sanitizes three full sets of patients' utensils in two loads . . . at a speed well within the normal discharge-and-admission rate. Simple and economical to install and operate, the Washer-Sanitizer saves personnel time, reduces utility room clutter and assures uniform cleaning and sanitizing at less cost.

For complete information on this new Utensil Technique,
write for bulletin SC-321.



**AMERICAN
STERILIZER**
ERIE • PENNSYLVANIA

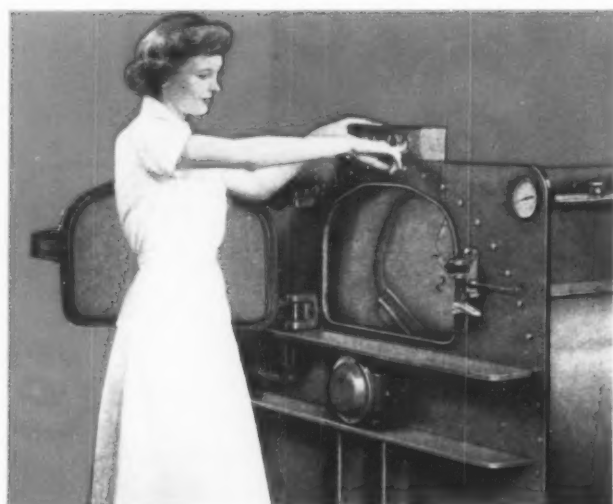
Offices in 14 Principal Cities



• The American Utensil Washer-Sanitizer is available with stainless steel utility room clean-up counter or as the free-standing unit shown above.

Institution Laundries report...

Outstanding savings with Cascadex Washer-Extractor



The American Cascadex Washer-Extractor is available in two sizes, 32" x 24" with 50-lb. dry weight capacity, and 40" x 30" with 100-lb. dry weight capacity. Both can be furnished manually operated, or air operated for use with automatic washing control. Choice of horizontal partition 2-pocket cylinder, or three Y-pocket cylinder. Exclusive Intermediate Speed between wash and extract cycles eliminates complicated balancing mechanism.

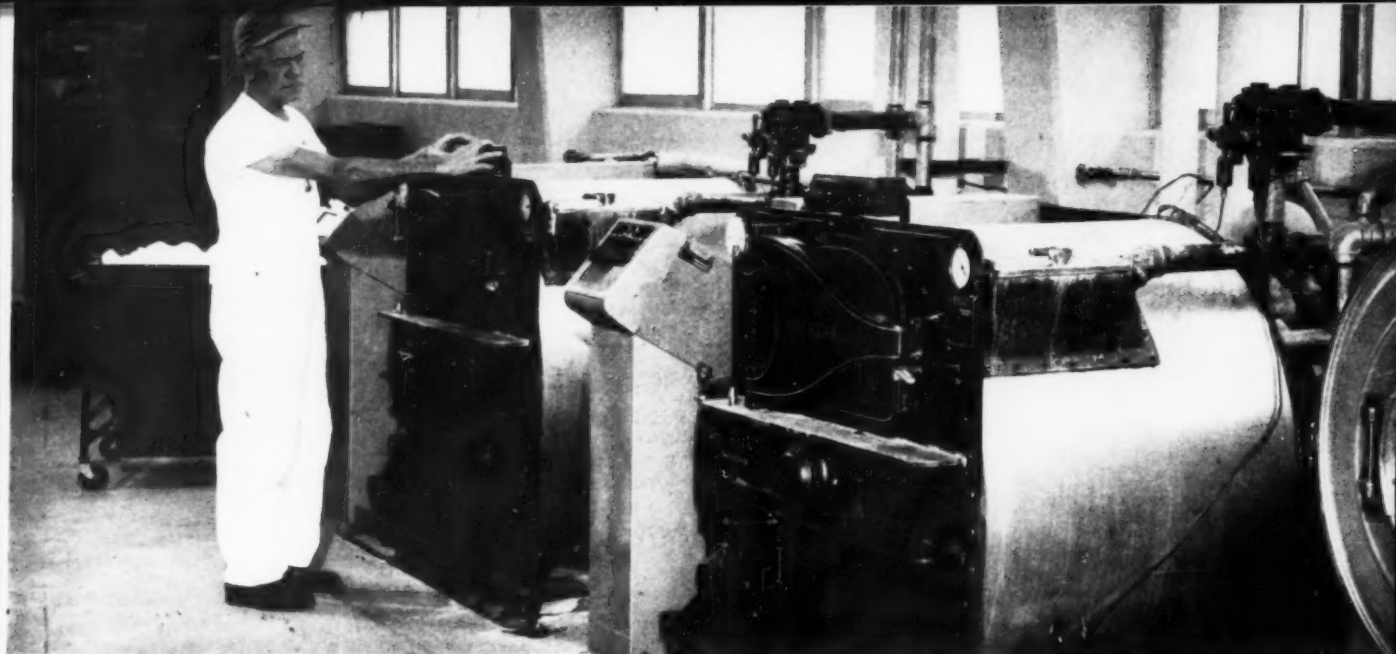
From hospitals and institutions all over the country come enthusiastic reports about the outstanding advantages of the American CASCADEX Washer-Extractor. They especially praise its high hourly production in so little floor space.

Combining highest quality washing and extracting in the same machine, the CASCADEX also saves labor by eliminating the necessity of attending two separate machines, and transferring wet work from one machine to the other.

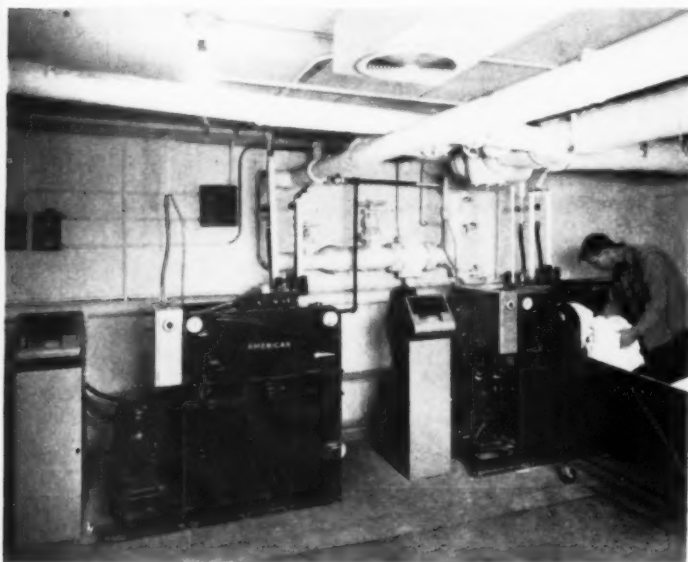
By reducing the number of rinses required, the CASCADEX saves water, too, and shortens total washing time. A final hot rinse before extraction speeds up ironing and drying of washed work.

Find out how the CASCADEX Washer-Extractor will make outstanding savings for your hospital or institution. Write today for Catalog AB 331-702.

The American Laundry Machinery Company • Cincinnati 12, Ohio



Smaller inventory and faster return of linens to central supply. That's the Cascadex story at St. John's Hospital, Longview, Wash. Their laundry department has two 40"x30" Cascadex Washer-Extractors with Cyclamatic Controls. These machines handle almost 9,000 lbs. of all kinds of work each week! Save equipment investment, too, combining top quality washing and extracting in one operation.



2 less operators are needed in this laundry since replacing old equipment with two 32"x24" Cascadexes. Equipped with Selectro Automatic Controls, these machines at Coeur d'Alene Hotel, Spokane, Wash., easily handle all of the various laundry requirements including linens, uniforms, blankets and towels.



"A nickel can be balanced on this 40"x30" Cascadex during extraction," reports Mr. Charles M. Charlton, Sup't. of Schenectady (N.Y.) Children's Home. Bolted directly to basement floor, the Cascadex has increased the laundry's production 30%, with less labor and savings in water and supplies.

You can expect more from

American



Ohio Chemical ... a member



"SERIES 2000" Kinet-o-meter®

for greater ease in attaining anesthesia

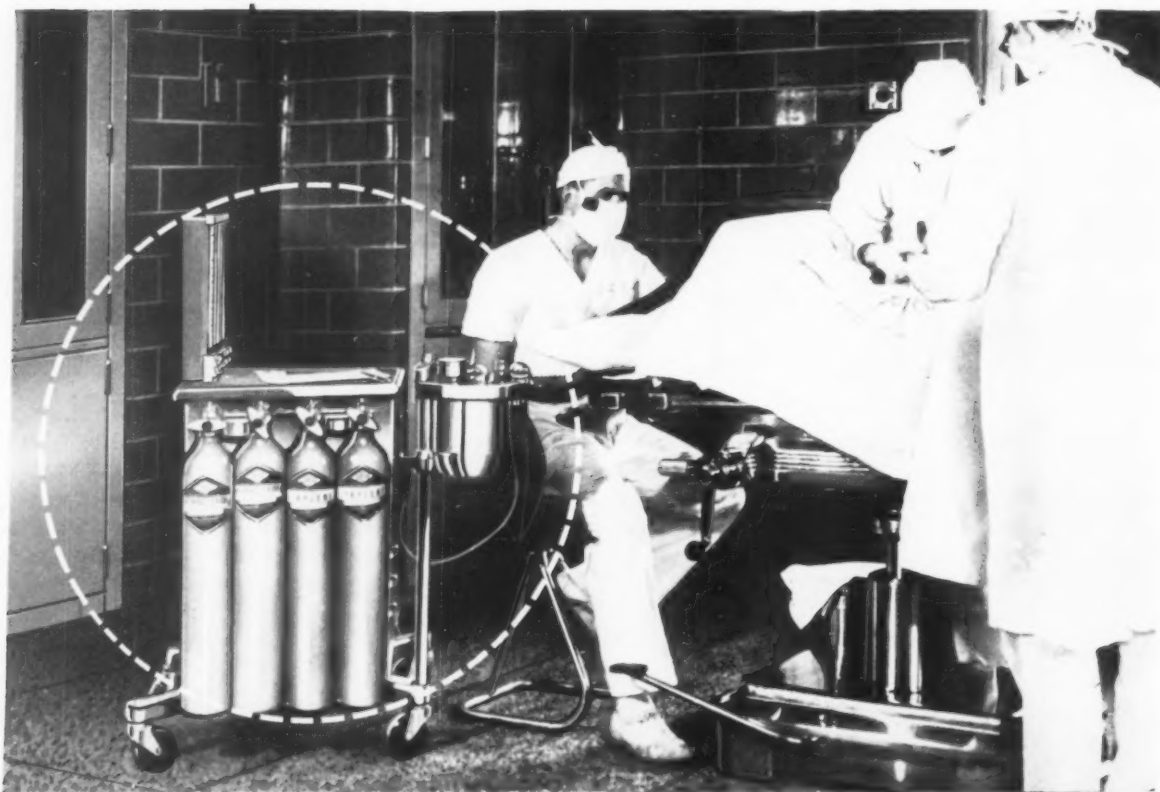
Ohio Chemical believes it the duty of the medical supplier to match increasing knowledge of anesthesia with the finest tools for its use. To this end, Ohio Chemical proudly presents the "Series 2000" Kinet-o-meter.

Especially noteworthy are the following advantages of this new model.

THE "VERNI-TROL" VAPORIZER

This new vaporizing system produces consistently high concentrations of ether vapor over long periods of time. Separate needle valves and flowmeters permit reproducible metering of oxygen through ether.

A special device circulates the liquid ether to facilitate absorption of heat from the surrounding area. This replaces heat lost through vaporization.



of the hospital team!

CIRCUIT CONTROL VALVE

The circuit control valve permits quick change of the "VERNI-TROL" from "Ether On" to "Ether Off." Inlet and outlet valves give a positive seal when "VERNI-TROL" is off. Opening oxygen flush valve shuts off ether flow.

LONG-SCALE FLOWMETERS

The 11-inch hand-calibrated flowmeters are easily read and their exceptional accuracy eliminates the need for "leveling devices." Two separate flowmeters each (high and low range) for oxygen, nitrous oxide and ether, provide an ample range for all techniques. Large visible floats are easily read against brilliant color background identifying the gases. A separate needle valve is provided for each flowmeter. *Models available with long-scale flowmeters only — less "VERNI-TROL" vaporizer.*

OTHER ADVANTAGES

In addition, the "Series 2000" Kinet-o-meter retains the "proved-in-use" features of the "Series 1000" Kinet-o-meter. All compatible accessories are available plus two new ones:

- B-D Mercury Column Type Blood Pressure Manometer Kit, complete with cuff, bulb, tubing, bladder and bracket
- A full-width handle for mounting on front or rear of cabinet

Catalog 4756 offers additional information, and our representative will be glad to call at your request to explain why the "Series 2000" Cabinet Kinet-o-meter is the ultimate in design and performance in an anesthesia machine.

OHIO PRODUCTS

MEDICAL GASES • THERAPY OXYGEN
CENTRAL PIPELINE SYSTEMS
ANESTHESIA AND ANALGESIA APPARATUS
OXYGEN THERAPY AND RESUSCITATION EQUIPMENT
STERIL-BRITE FURNITURE • SURGICAL SUTURES AND NEEDLES
STILLE SURGICAL INSTRUMENTS

OHIO "Service is Ohio Chemical's Most Important Commodity"

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.

MADISON 10, WISCONSIN

At the frontiers of progress you'll find An Air Reduction Product • Ohio: Medical gases and hospital equipment • Airco: Industrial gases, welding and cutting equipment, and acetylene chemicals • Parco: Carbon dioxide, liquid, solid ("Dry-Ice") • National Carbide: Pipeline acetylene and calcium carbide • Colton Chemical: Polyvinyl acetates, alcohols and other resins.



OTHER OHIO AIDS FOR ANESTHESIA



WOODHULL ADAPTER

The Woodhull Adapter (available in both 11 mm. and 15 mm. connections) allows coupling intra-tracheal catheter to gas machines at variable angles. The universal ball joint eliminates sharp angular turns, and reduces air turbulence. The added freedom of movement of the Woodhull Adapter makes it desirable in neurosurgery.

JACKSON TRACHEOTOMY TUBE

This silver tube with standard 11 mm. tapered outlet permits connection to standard anesthesia intra-tracheal fittings. This allows easier administration of anesthesia to patients who have undergone tracheotomy. Both tube and fittings can be used with a minimum of clearance. A lightweight elbow can be easily removed for suctioning. Outside diameter of cannula ranges in eight sizes from 4 mm. to 12 mm. For more details, request Catalog No. 4727.

ESOPHAGEAL STETHOSCOPE

The Ohio Chemical stethoscope receives more audible heart and respiration sounds as the transducer is placed in the esophagus. Connecting tubing contains a Luer-Lok union. Complete kit includes an acoustical transducer, connecting tubing and a self-retaining ear piece. For more details, request Catalog No. 4757.

INHALER "Y"



The "Y" is of durable, lightweight die-cast aluminum. With the 90° (15 mm.) mask elbow, the anesthesiologist or anesthetist quickly can switch from the mask to either the oral or nasal catheter. It can be had with or without an exhalation valve, and in both the 11 mm. and 15 mm. catheter connector slip-joint fittings. For additional information, please request Form 4757.

S-C-R-A-M® MASK

The SCRAM mask can be shaped to fit any facial contour. The malleable ring and plastic cushion can be formed to fit comfortably with a minimum of dead space. Molecular structure of rubber compound furnishes needed conductivity. Available in small, medium and large sizes. For more details, request Catalog 4689.

Clarke

INTRODUCES A NEW LINE OF WET-DRY VACUUM CLEANERS

Designed with a host of efficiency features for fast, easy pickup of dust, dirt and liquids — cleaning everything from floor to ceiling. They're user-inspired features, based on a survey that told us just what you want in a vacuum cleaner. *And only Clarke has them.*

- Stainless Steel Tank • Big, Easy Roll Wheels • Feather-Touch Switch • Quick-Connect Hose Coupling • Automatic Shut-off Valve • Easy Lift Clamp Handles • Job Designed Turbines • Correct-Height Handle • Wire Tool Basket • Revolutionary Air Disposal • Polished Aluminum Head • Automatic Blower Connection • New Job-Designed Tools.



Wet or Dry Pickup



Easy Carpet Cleaning



Furnace Boilers, too

DIFFERENT SIZE UNITS TO MEET EVERY NEED

SEND TODAY FOR BROCHURE

ON NEW CLARKE WET-DRY VACUUM CLEANERS

Tells all about the new line, the many new features, and shows you why time-and-labor-saving Clarke vacuum cleaners are the most outstanding buy in the maintenance field. Send coupon.

Name _____

Individual _____ Title _____

Address _____

City _____ State _____

Dept. 529

See the complete Clarke line at
Booth No. 227

AMERICAN HOSPITAL CONVENTION
Convention Hall — Atlantic City
Sept. 30-Oct. 3

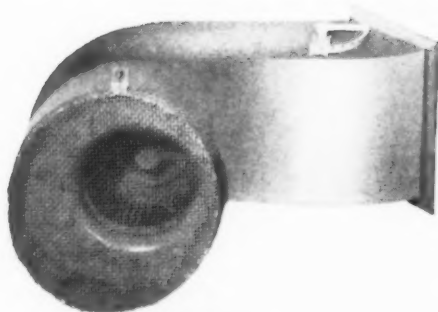


Clarke

SANDING MACHINE COMPANY
529 E. Clay Ave., Muskegon, Michigan

Authorized Sales Representatives and Service Branches in Principal Cities
Distributed in Canada: G. H. Wood & Co., Ltd., Box 34, Toronto 14, Ont.

1 extra inch gives 20% more air in a Purkett Conditioning Tumbler and speeds up production



**More drying in the same
length of time with
shorter tumbling cycle
possible with the new
6-inch squirrel type fan.**

Mark up another improvement in the 72" 12-ring Purkett Pre-Drying Conditioning Tumbler . . . another example of keeping the Purkett far ahead in large flatwork and garment conditioning operations.

By increasing the size of the fan but one inch and using a larger 1 1/2 hp. motor with a larger duct, production is speeded up. To the operator this means a shorter tumbling cycle with the same amount of drying possible, or more drying in the same tumbling time may be obtained.

This is but one of many features described in a new folder which will be sent gladly upon request.

Purkett Consulting Service

Without cost or obligation to you, ask for a Purkett engineer to help you solve your special problems. He is a specialist in linen and garment conditioning.



*Naturally
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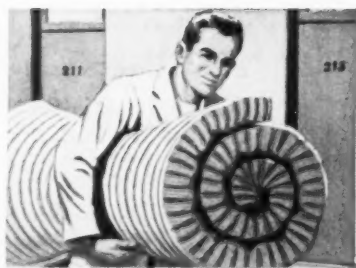
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SMALL HOSPITAL QUESTIONS

Delivery Room Is Off Limits

Question: We have always excluded fathers from the labor and delivery rooms on advice from the medical staff, but recently a clergyman in our community has insisted this practice is obsolete and harmful to the family for emotional and spiritual reasons, because it bars the husband from "the most important event of life." Should we change our policy? What do most hospitals do?—D.M.H., Iowa.

ANSWER: Most hospitals exclude husbands from the delivery room area, although a few have relaxed this regulation in recognition of the emotional aspects of the "natural childbirth" and "rooming-in" programs. However, the evidence, and the overwhelming weight of authority, is that the major source of infection in hospitals is street clothes, including shoes, worn by visitors and staff members who do not change into hospital clothing immediately upon entering the hospital. The presence of such infection is most serious in surgical and obstetrical cases; in the latter, both mother and child are especially susceptible immediately after birth of the baby. When these facts are explained, few husbands would insist, or even consent, to being present in the delivery room, knowing that their presence could increase the danger of infection.

Where to Put Septic Cases

Question: The question has arisen in our hospital whether or not to continue placing patients with purulent drainage, such as ruptured appendix or draining orthopedic cases, in the post-anesthesia room and surgical floor. Any information or assistance you can give will be appreciated.—R.M.S., Minn.

ANSWER: This question was referred to a technical consultant, an authority on aseptic technic, who replied as follows:

"Patients with freshly drained sepsis present a minimal problem in the operating room and in the recovery room. Terminal sterilization following septic cases ends all hazard. In the recovery room, the patient presents the problem of a safe, no touch, dressing technic should the dressing require changing.

"Patients with sepsis are a hazard to their environment because wound discharges seep through the dressings

and dry in the outer layers. Bacteria are then shed to the bedding and fingers. During dressing changes and bed making, these bacteria become airborne and are distributed. Ambulatory patients with sepsis shed organisms as they move about. For this reason, they should be confined to their own room or cubicle."

Nursing Home Loans

Question: In a recent Washington column, your magazine reported that nursing homes are eligible to receive "long-term, low interest" loans from the federal government through the Small Business Administration. Is this something new? We were informed that S.B.A. loans are for a maximum of 10 years at 6 per cent interest—terms that hardly fit the description your correspondent used.—M.K., Ill.

ANSWER: Probably the description was not justified. In some cases under the present regulations, S.B.A. loans to nursing homes might be for as long as 12 or 13 years, and in some cases the interest could be lower than 6 per cent, if a bank wanted to make these terms—but it is expected that low interest rates will be exceptions.

Minimize Hepatitis Hazards

Question: We keep reading and hearing about the danger of transmitting hepatitis as a result of inadequate sterilization procedure in the hospital. What is the actual hazard, and what can the hospital do to minimize the risk?—P.D.I., Tenn.

ANSWER: Viral hepatitis may be transmitted during transfusion or when contaminated needles are used for any kind of injection. Inadequately steril-

ized needles, syringes, lancets or other instruments may transmit infections. To minimize risk, the appropriate medical staff committee or authority should review transfusion indication and technics and make certain transfusions are ordered only when absolutely necessary. Blood donors should be selected and studied with extreme care to screen out those with any history or other evidence of hepatitis.

The following instructions for sterilization were recently set forth by one medical society committee, following study of the problem: "Instruments should be sterilized by boiling for 30 minutes, dry heat for two hours, or by autoclaving for 30 minutes at 15 pounds pressure. Blood-letting objects and lancets are not adequately sterilized by immersion in alcohol. Physicians, interns, nurses and technicians should be on constant guard and maintain isolation in the examination and treatment of patients with viral hepatitis."

Cost of Selective Menu

Question: Having visited larger hospitals elsewhere, several of our doctors and trustees have asked why we can't have selective menus for patients in this 35 bed hospital. It has seemed to us this would be impractical and costly in a hospital this size. Are many hospitals in our group doing this now?—A.S.A., Mo.

ANSWER: The practice is not widespread in small hospitals, but many of these hospitals have introduced selective menus, or partially selective menus, without adding to food costs, and some even claim costs are reduced because less food is returned to the kitchen uneaten. A "partially selective" menu, for example, might offer a choice of soups, vegetables and desserts with a single meat dish and salad. A choice of fruit juices and cereals may also be offered on the breakfast menu without greatly complicating food service operations, it has been reported.

Menus for the following day are distributed to patients, who check their preferences as indicated. Food service supervisors report this system can be operated without additional help. Patients are better satisfied with their meals when this attempt is made to give them some choice, it is evident.

Conducted by Jewell W. Thrasher,
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• On the two largest unoccupied building sites on Chicago's "Gold Coast," overlooking Lake Michigan, a \$25-million, 6-building apartment enterprise is rapidly nearing completion. These 28 and 29 story towers will be the tallest flat-slab reinforced concrete structures in the U.S. and possibly the world. Prefabricated skin frames of aluminum, each a story high, will hold crystal walls of gray tinted, heat retarding plate glass. All of the 1238 apartments (6108

rooms) will be summer and winter air-conditioned and equipped with individual room controls. All will feature maximum soundproofing for quiet privacy. All will be served by high speed, electronically teamed elevators and all corridors will be pressurized. In a project of such fabulous designing nothing less than the best would suffice, hence all towers are to be equipped throughout with SLOAN Quiet Flush VALVES and SLOAN Act-O-Matic SHOWER HEADS.

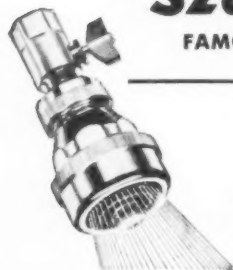
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ASIAN INFLUENZA

In the Asian flu situation, complications are building on complications and no one can say what the picture will be when the normal influenza season reaches its height of incidence. But if disaster results—and that is a possibility—it will not be because the health professions are not cooperating with each other and doing all they can to set up defenses.

Since spring, leaders of the American Hospital Association and American Medical Association have been kept up to date on developments by U.S. Public Health Service and have cooperated with P.H.S. in all phases of planning.

But regardless of all the research and all the planning, there are some problems that haven't been answered.

The six pharmaceutical houses now licensed to make the vaccine are producing beyond their own goals, but there is no possibility that there will be enough available to vaccinate all the people who want shots.

Public Health Service has suggested that personnel responsible for health and other essential community services be given priority—but who is to draw a line to say which occupations are unessential?

Already national magazines are coming out with popularly written articles about the disease, articles that without question are stirring up some of the "hysteria and fear" that Surgeon General Burney hoped to avoid. At the same time publications in the educational, scientific and health fields are printing volumes of information on Asian influenza. All of this is adding up to (a) intense public interest in the disease, (b) fear for the worst, and (c) a desire for protection from a danger some elements of which are unknown.

From the public health aspect, the publicity is designed, first, to educate the public to the value of vaccinations; and second, to explain why some people won't be allowed to receive the protection they have been convinced they should have. It's a neat public relations trick if it can be done, but obviously it can't.

With the vaccine in short supply, how can the manufacturers hope to perform the magic of allocating equitably, taking into consideration the factors of population and special risks in crowded urban areas, and still hold out enough to stop all the prairie fires of epidemics that are anticipated?

Nor is there any answer at all to the question raised by the researchers and epidemiologists themselves: Will this disease grow in virulence (as did the 1918 flu) and sweep the death rate up to catastrophic scale? If this does happen, when? Before we have enough vaccine, or after?

A special influenza committee of the American Hospital Association, under the chairmanship of Dr. Dean Clark, has headed up the hospitals' efforts. It has met frequently with P.H.S. officials as the disease progressed, hearing

reports and helping to brace the country to meet the epidemic.

In a special A.H.A. bulletin, the committee is attempting to give guidance to hospitals. It urges that hospitals keep in close touch with medical societies, and that influenza information in professional publications be followed carefully. Directors are reminded that hospital staffs are included in the present priority list because of earlier and higher exposure, and directors are advised to apply early for vaccinations.

Also, medical staffs are urged to form special committees to deal with influenza problems at the hospital, and directors are advised to set up other committees composed of department heads to work with the special medical committees.

A.H.A. also is pointing out to the hospitals that influenza cases (hospitalization recommended only if there are complications) should be subject to strict communicable disease precautions, particularly to save tuberculous patients from contamination if possible.

Like the A.M.A., the hospital association is attempting to handle its responsibilities by stimulating the proper preparations at the state, county and hospital level.

(For pictures and further discussion of hospitals' problems in dealing with the Asian influenza epidemic, see next page and Page 148.)

LOANS FOR STUDENT HOUSING

Community Facilities Administration, just launching into the business of making loans to hospitals for intern and student nurse housing, has drawn up regulations that provide, among other things:

1. Only public and nonprofit hospitals eligible.
2. Period of loan may be 50 years, but these loans will be limited to 40 unless "special justification exists"; interest rate is set annually (currently 3 per cent); loans may cover all of the project.
3. Elaborate or extravagant design or materials are ruled out.
4. Outside help—brokers, and so on—not necessary to negotiate loan.

In announcing that the program was ready to get under way, C.F.A. Administrator John C. Hazeltine said: "Each loan must be sound and stand on its own feet, backed by pledges of specific income to amortize it. No grant is involved and the loans must be repaid in full with interest. The transaction is similar to a loan negotiated with private lenders and adequate safeguards are employed to protect the interest of the federal government."

A \$25 million fund is available, but in no one state may institutions obtain loans totaling more than \$2.5 million.

For full details, contact regional offices of Housing and Home Finance Agency, under which Community Facilities Administration operates.

HOSPITAL PROTECTS PERSONNEL AGAINST FLU; 750 VACCINATED

Brooklyn, N.Y.—Some 600 staff members of St. John's Episcopal Hospital here were vaccinated against Asian influenza the week of August 16 to 23, in accordance with urgent recommendations of Public Health Service officials and other medical and health authorities.

In a bulletin issued August 22 by the American Hospital Association, it was pointed out that hospital staffs and personnel should be inoculated as early as possible to prevent "a grave personnel shortage at the very time increased demand for admissions may be anticipated."

At St. John's Hospital, Administrator Melvin Dunn reported, Dr. Thomas Allen McCormick, a staff doctor, was put in charge of the inoculation program. Starting with 75 student nurses, a group of 200 key hospital personnel was vaccinated in a two-hour period. By the end of the day, nearly 300 shots had been administered and the remainder were given in the next few

days as more vaccine became available through a regular source of supply.

In addition to professional and non-professional personnel, Mr. Dunn explained, the vaccine was administered to members of the hospital's board of managers and also to approximately 100 residents of the institution's Home for the Aged. Altogether, a total of 750 vaccine shots was administered. Vaccination of aged and long-term patients was recommended also in the American Hospital Association bulletin.

Other measures urged upon hospitals by the A.H.A. include the establishment of procedures to limit or deny all elective hospital admissions during the epidemic, if this should prove necessary, and setting up strict isolation technics. In regard to the admission of patients suffering from influenza, it was suggested that, as far as possible, admissions should be limited to "cases of influenza complicated by pneumonia, and to cases with cardiovascular, pulmonary or other chronic diseases

which might be aggravated by influenza."

Isolation of influenza patients will be essential, it was pointed out, first to keep to the absolute minimum dangerous cross infections in the influenza patients and, second, to prevent the spread of influenza throughout the hospital. "Patients with influenza should be housed in areas of the hospital as far away as possible from potential sources of bacterial infection. . . . No visitors or personnel other than those directly engaged in the care of influenza patients should be permitted to enter the area where influenza cases are housed," the bulletin stated.

Medical authorities advise against giving antibiotics to uncomplicated cases, because they have no effect on the Asian virus. Hospitals were strongly urged to make certain that their laboratory services can quickly identify complicating bacteria "so that the proper use of the antibiotics in complicated cases can be facilitated."



Left: Key personnel of St. John's Episcopal Hospital, Brooklyn, N.Y., including maintenance chief, staff nurses, faculty members, and laboratory personnel, await their turn to be vaccinated. Approximately 200 were vaccinated in a two-hour period. The first supplies delivered to the hospital included enough vaccine for 450 persons. Additional supplies were received later in the week so that a total of 750 injections was given. Below, left: Student nurse receives the first inoculation from Dr. Thomas A. McCormick, staff doctor in charge of the program. Below, right: Next customer—the chef. Injections were given also to 100 residents of Home for the Aged, a division of the hospital, and to members of the board of managers.

(For earlier story on Asian flu, see Page 148.)





Politics

THE emergence of organized campaigns on behalf of candidates for the office of president-elect of the American Hospital Association is a recent phenomenon that is viewed with regret by some old-timers in the hospital field. This year, campaigns for two of the candidates have been announced publicly, and others also have organized backing. "I hate to see our association become so politically minded," one long-time member observed, commenting on these campaigns.

We think this view is dead wrong. Contests for the presidency, it seems to us, are a wholesome sign of association strength and political maturity. As the association grows in size and influence, the office grows accordingly in importance and desirability. It is natural for strong men and women to aspire to be elected and seek support for their aspirations, and it is natural for geographic and other groups to promote the candidates of their choice.

Why is that bad? In our society, open campaigns and contested elections are the accepted method; as long as the campaigns are dignified and the elections honest, there is no reason the method shouldn't be used in a professional association, and it may be expected to produce leaders of equal

quality, at least, to those selected by little groups of king-makers operating behind closed doors.

An association by its very nature is a political organism. The best way to keep politics clean is to keep political activity out in the open, where everybody can see what is going on.

Poll Problems

A RELEASE from an Eastern hospital reports that an opinion poll among former patients indicated more than 90 per cent were favorably impressed with the hospital and would return if they needed hospital care again. Only 10 per cent thought their hospital bills were too high, the report said.

Well, great. The hospital's desire to find out how patients felt about their service is commendable, and 90 per cent must be considered a high score. But we have misgivings about opinion polls on anything as complex as hospital care, just as we have misgivings about our own reader surveys, which invariably show an enthusiastic majority proclaiming *THE MODERN HOSPITAL* as the greatest thing since the New Testament.

It is comparatively simple to conduct a canvass among a statistically sound sampling of citizens to find out,

for example, how much they paid for medical and hospital care during the last month, or the last year. If they kept records, they can look them up, and if they didn't, they can probably remember within fairly close limits, and so you can get a factual answer that is close to the truth for most families. It is also a simple thing to ask a representative sampling of the general public which of two candidates for public office they prefer and are going to vote for at a coming election. Most people know and will tell you, so you can predict the outcome of the election, again with only a small margin of error, and thus surveys and opinion polls have gained a great deal of acceptance. But it is questionable, at least, that the survey method is an accurate one for measuring such a very different matter as the public feeling about hospitals. A quick look at the results of a few opinion polls about hospitals shows how deceptive they may be. In one such poll conducted not long ago by one of the most widely known and highly respected research organizations in the country, for example, only a negligible number of respondents even mentioned the price or cost of hospital care as one of their concerns, and the single hospital poll reported here shows only 10 per cent of patients

finding their bills too high. On the other hand, another recent poll, also conducted by a reputable research firm, found that 51 per cent of the respondents thought their hospital bills were too high.

What happened? Well, it turns out, the surveys were conducted by entirely different methods, and for very different purposes, with the result that the interviewers approached the question of costs and hospital bills from such different directions, and in such different ways, that they got these divergent answers. One survey was aimed at determining how people feel about the hospitalization experience, and the method was to conduct detailed interviews with respondents, allowing them to talk freely, without any more questioning than was necessary to keep them going, about hospital care—and, of course, most of them talked about doctors and nurses and operations and pain and fear and the way they felt about the hospital, and, as might be expected, they never got around to talking about costs at all.

In the survey that showed more than half the respondents concerned about their hospital bills, on the other hand, interviewers asked a set of detailed questions, and one of the questions was, "Do you think your hospital bill was higher than it should have been?" and of course a substantial number said yes.

The single hospital poll was meaningless on this subject, as it was on the other questions covered, because the number of nonrespondents was not reported. If half or more of the people who received questionnaires threw them away, as they usually do, the figures plainly don't mean what they appear to mean at all. Not 90 per cent of patients, but 90 per cent of a group identified only by their willingness to respond to a question on the subject, felt good about the hospital—a circumstance that is unquestionably comforting to the management and is better than no information at all, but not very much.

The point is that when you read a report stating that such and such a percentage of people think hospital bills are too high, or doctors are too high-hat, or that x per cent of people love nurses, or y per cent hate nurses,

it doesn't mean anything unless you know all about the reasons the survey was conducted, and the methods used, and the questions asked, and the nature of the response—and even then it doesn't mean too much, because the nonrespondent group remains an unknown quantity, and because in measuring this kind of feeling or response it has been demonstrated that you can go back to the same people and ask the same questions at a different time, and get an altogether different set of answers. All this means is that people change their minds.

This is not to say hospitals should abandon all efforts to find out how people feel about hospital service. Such efforts must be continued, of course. But if they are to prove anything, the questions must be asked and the answers analyzed by somebody who knows the public opinion business, and, even then, hospital administrators should view the results through squinted eyes, the way a man looks at the final figure on his income tax form: It's down there in black and white, but he still doesn't believe it.

Flu

THE expected epidemic of Asian influenza, if it occurs, may make heavy demands on hospital facilities and services in some U.S. cities this fall. Some idea of the magnitude of the problem may be gained from an American Medical Association release indicating that the expected attack rate would run between 15 and 20 per cent of the population of any area where the disease reached epidemic proportions. While home care is adequate for most patients having uncomplicated influenza, hospitalization is required when complications do occur, and, if the epidemic is severe, it is expected that many persons may be stricken while away from home and may require a few days' bed care in hospitals.

Medical and public health authorities are organizing plans to make certain physicians everywhere can mobilize medical resources in case of epidemic. Hospitals that have not already done so should coordinate their own emergency plans with those of county medical societies and health depart-

ments so that hospital facilities can be made available as needed in any influenza outbreak.

Productivity

HOSPITAL costs are going up and up, because payroll costs are 60 to 70 per cent of total costs, and, since hospital service is so highly personalized, hospitals cannot avail themselves of automation to improve the productivity of the individual worker, the way industry does.

This proposition has been widely stated and believed in recent years, and yet it may not be as true as many hospital people think. While it is unlikely that the machine is going to replace the nurse, there is evidence that worker productivity can be improved, even on highly personalized nursing floors. For example, a Public Health Service study reported elsewhere in this issue (*p.* 72) indicates that graduate nurses may be spending as much as 37 per cent of their working time getting ready to serve patients—gathering supplies, this means, since the floor nurse doesn't have to scrub, as the surgeon does, or limber up like a baseball pitcher.

Obviously, a nurse who spent less time spitting on her hands, so to speak, could spend more time with patients, and serve more patients, thus increasing her productivity. In another report in this magazine (*p.* 55) a hospital consultant describes a supply system that puts everything the nurse needs, from catheters to bobby pins, in one location and is expected to cut down sharply the amount of time she spends collecting supplies. The same hospital consultant has proposed an extension of this plan under which every hospital room would be supplied with a daily complement of needed materials put in place by supply crews working at night—an arrangement similar to the familiar hotel "Servidor" system—so the nurse coming on duty in the morning wouldn't have to spend any time at all getting supplies.

But hospital people have been cool to this proposal. It wouldn't work, they tell the consultant. You see, they add, hospital service is highly personalized, so hospitals can't increase worker productivity, the way industry does.

"The main thing is that the mechanism of financing medical care should not impair free selection of the physician and the application of his talents to the care of the sick," says



MEDICINE'S NEW GENERAL MANAGER

A Modern Hospital interview with Dr. F. J. L. Blasingame

DR. F. J. L. BLASINGAME (pronounced Blasing-game), whose appointment as general manager of the American Medical Association was announced last month, believes the nation's health services must be developed independently, community by community and area by area—with doctors, hospitals and other interested groups working together and resolving their differences, if any, without recourse to government, national organizations or other outside authority. Government assistance, especially, is abhorrent to Dr. Blasingame, who has practiced medicine and surgery in a 40-bed hospital of which he is part owner in Wharton, Tex. (population 7500), for the last 20 years. Like most physicians, and most Texans, he regards Washington handouts with combined aversion and alarm.

Unlike some who share these views, however, Dr. Blasingame expresses his opinions in relaxed, soft-spoken tones, choosing his words carefully and resorting to epithet only occasionally. "I doubt if it will work, but let's see," he said several times during the course of a recent interview with *THE MODERN HOSPITAL*, describing how he felt about experimental programs in medical care and medical economics.

A graduate of The University of Texas and The University of Texas

Medical School at Galveston, Dr. Blasingame, who is known to his friends as "Bing," taught anatomy there until he entered practice at Wharton in 1937, and he maintains the scientist's calm detachment as he talks about the complex problems of medical service. His general appearance and easygoing manner today, at 50, are reminiscent of a contemporary in another line of work who is also known to his friends, and others, as "Bing."

Actually, there is nothing easygoing about Dr. Blasingame, who in addition to his busy practice has maintained a teaching connection at The University of Texas through the years and has also been active in state and national medical affairs, having been one of the youngest physicians ever elected to the position when he became a member of the A.M.A. Board of Trustees in 1949.

When he takes over his new duties as A.M.A. general manager in Chicago next January, Dr. Blasingame will become one of the most influential men in American medicine. To give the nation's hospital administrators and trustees an opportunity to know his views on the important issues and trends of the day in medical and hospital practice, Dr. Blasingame granted an interview to *THE MODERN HOSPITAL* when he was in Chicago recently attending an A.M.A. board meeting.

Here, in his own words as recorded during the interview, is what Dr. Blasingame thinks about the problems physicians and hospitals must face and solve together in the years ahead.

DR. BLASINGAME:

The Hospital-Physician Relationship. Hospitals are institutions of service. In that objective is implied a cooperation between the people who are responsible for giving medical care from a professional standpoint and those who are responsible for maintaining the facilities, and their efficient operation. There shouldn't be any fundamental conflict of interest between the two groups if the primary objective of the institution is kept in mind.

The financing of medical care is complicated, and the main thing to keep in mind is that the mechanism of financing should not impair the freedom of selection of the physician and the application of his talents in the care of the sick. However, the arrangement must be made in such a way that it is economical in the operation of the institution and economical in rendering service to the patient. The hospital without good medical care is just a building.

In the operation of any hospital, financial problems are a major consideration. With the cost of labor, the

"We are doing
a commendable job
in the care of
the American people.
I think they know it
and appreciate it."



"The hospital accreditation program has a wholesome, beneficial effect."



"If medicine is dependent on government we can expect controls."

cost of materials, and the cost of replacement going up, the hospital has economic problems that face it constantly. However, these must be solved in the realm of economics, without interfering with the basic philosophy in the care of the sick.

Selection of Hospital Staff. Serious consideration must be given to the arrangement by which the medical staff is selected. I believe it is essential to review carefully the qualifications of every staff member; and that this evaluation of a physician should be at the local level, in terms of his capacities as observed by his professional peers. A man is best known by those who live with him day by day and can judge his capacities. It is the responsibility of the medical staff of a hospital to examine carefully the record of work of its members and to express its opinions to the board of trustees, or legally responsible authorities who operate the hospital, and to give advice to them on the technical and professional ability of staff members. The board of trustees alone cannot evaluate the services of a physician, but by a cooperative effort, intelligently applied with mutual respect, the staff can be of great assistance to the board of trustees in arriving at sound recommendations for staff membership and in keeping them current. The hospital trustees and all the employees are dependent on a well operated and organized staff.

While there may be personality differences—some strong and some weak individuals or an occasional careless individual—we must not criticize the method or the potential good that can come out of soundly conceived procedures because they fail to function in a particular instance.

Hospital Accreditation. In general, the hospital accreditation program has had a wholesome, beneficial effect. It's an expensive program to carry out. I think it is important that the accreditation commission keep men employed in the field who are technically trained and who are philosophically sound, so that they go out and evaluate hospitals in an attitude of helpfulness. This is a voluntary program, and its representatives should not be looked upon as policemen coming to remove privileges, but rather in an advisory, constructive, helpful evaluation.

The commission also has a responsibility to see to it that its rules and regulations do not become so detailed and technical as to require procedures that are repetitious or involved to a degree that it becomes a burden that will increase the cost of medical care beyond what is necessary. In the operation of a hospital, it is essential that good records be kept.

Problems of the Small Hospital. I think the commission might very well give consideration to reviewing carefully and critically the inspections as applied to smaller hospitals. Many of the regulations were conceived to apply to large institutions where manpower is plentiful, or tends to be more plentiful, while these same regulations can become burdensome and almost meaningless in smaller institutions. Certain large hospitals have problems of communication between departments and between various areas of the hospital that are not necessarily similar in smaller institutions.

Such a large number of patients are cared for in small hospitals that they deserve every consideration. It might even be advisable for the commission to consider the adoption of a

set of suggested guides specifically designed to apply to hospitals having even less than 25 beds. The larger institutions tend to be well staffed and well administered, and the commission can provide a significant service by considering the responsibility of the smaller institutions very seriously. I'm sure it is doing so—I'd like to recommend that the commission keep these small institutions uppermost in mind, because of the great number of patients served in small institutions.

We want to encourage the wide distribution of medical care and hospital facilities. We want those institutions to be of good quality. The commission is the organization whose responsibility it is to assist in elevating standards of care in the more sparsely populated areas as well as in metropolitan centers. Of course, you reach a point beyond which it isn't economically feasible to have a hospital, any more than it is to have a steam laundry at every crossroads, but, with modern transportation and communications as they are in this country, the proper distribution of hospitals as to trading areas is essential.

Area Hospitals. Area hospital development, it seems to me, needs to be encouraged. I think we have come a good way in developing community hospitals. We've come a good way in developing our large teaching institutions. Now I believe attention needs to be given to the development of economically sound area facilities, institutions that can be sustained by a competent staff and by a surrounding area that needs the service of an intermediate hospital—in between the hospital of 10 or 15 beds that can take care of the garden-variety things and the large, urban hospitals. The



"Smaller hospitals have problems that are not the same in large hospitals."



"The ideal is for every practicing physician to have access to a hospital."



"Hill-Burton has accomplished a great deal in distribution of facilities."

establishment of regional hospitals will do a great deal to assist in the distribution of medical care and will improve the services physicians are able to give a wider group of our population on a more economical basis. Furthermore, the general practitioner would have competent assistance available and be able to provide better service nearer home—thus dislocating families to a lesser degree and giving them medical security which they want and need.

In addition, training of laboratory technicians, nurses, x-ray technicians, and the like is the responsibility of such a regional hospital. People tend to marry, to buy real estate, and want to live in an area where they are trained, and we would encourage the wider distribution of allied personnel by having such facilities.

The Hill-Burton Hospital Construction Program. My views about the Hill-Burton program are somewhat mixed. When you start a program at the federal level, there's some difficulty in determining its reasonable bounds—there's a tendency to expand here and expand there. In general, the Hill-Burton program has accomplished a great deal in wider distribution of hospital facilities, especially in the smaller areas, and of course it has also assisted in some of the suburban areas and even metropolitan centers. I think it was also an economic necessity in some areas, if you consider the amount of the nation's wealth that is being carried centrally to Washington, leaving local communities with a relatively small amount of money so they have to turn economically for financing from the national level. In other words, use of federal funds is a symptom of local economic stress, in many instances, rather than a lack of interest on the

part of the local people to create a hospital facility.

The Hill-Burton program has been expanded from year to year, and I think we now need to examine real needs for the construction of hospitals. Considerable study needs to be given to the economic feasibility of an institution being able to sustain itself. A hospital must have a sound economy on which to exist; there would be no point in creating one unless there is a genuine economic basis for sustaining it.

Personally I would rather see our hospital facilities developed on the basis of local resources, but living in modern America local people often are not able to do so because of the tax situation; their wealth has been removed from them to a degree that they feel they must turn to federal aid.

Specialization in Medicine. I should like to comment on the regional hospital from the standpoint of its assistance in bringing special care to local areas. There is a tendency in medicine, as it has become more complicated, toward the development of specialists. Approximately 50 per cent of the practice now is done by individuals who have special interests and special training. It takes a larger population to support a specialist—an x-ray man or urologist, for example. He also has to have, in general, more facilities, because his cases are often more complicated and technically more difficult to handle than many of the everyday, shorter illnesses that can be taken care of either at home, in the office, or in a small community hospital. Thus a wider distribution of special facilities, and through that mechanism a wider distribution of specialists, will assist the general practitioner in rendering

his medical services. It does not necessarily follow that we are overspecialized. We simply don't have the facilities for bringing special talents nearer to the places where they are needed. Hospital facilities in the area can do a great deal toward bringing the specialists nearer to the need, where they can be of service to the patient and to the general practitioner.

I want to make it clear that I feel each individual should have his personal physician. In most instances, the family physician or general practitioner serves that purpose very well and very wisely, and a close, friendly relationship between the general practitioner who knows the family life and knows the habits and ambitions of his patients is indispensable in the day-to-day application of medical knowledge in this country.

The General Practitioner and the Hospital. The relationship of the general practitioner to the hospital is fundamental. His patients will want him to continue to be responsible for some degree of their care. However, it's apparent in the treatment of an individual who becomes seriously ill, and for whom consultation is needed, that the management of a particular illness may have to be limited to only one individual, and that may be the specialist, if that is the wish of the patient and if that is the best arrangement for getting the illness relieved. The responsibility of a general practitioner on the staff of a hospital, whether it be a small, community hospital, or a regional hospital, or a teaching hospital, should be judged on the same basis as that of a specialist—whether or not this man is competent and conscientious and effective in the day-to-day practice of medicine. The effect of his

services on the patient, as judged by his peers locally, is worth more than any other evaluation.

The ideal is for every practicing physician to have access to a hospital. A physician may be so remotely situated that this is not possible. There may be some areas in which distance would preclude his doing so, but he should know where good hospital facilities are and be able to recommend such facilities in which his patients may be treated. A competent physician should be able to find a place to treat patients who want to be treated by him.

I think a condition that obstructs a competent physician from the managing of patients needs to be seriously scrutinized at the local level—by the staff and by the board of trustees responsible for the operation of the hospital. That is a local problem which can be handled, and should be handled, at the local level. It is not necessary and it is not wise for a state or national medical society to step in and tell a local community what it should or should not do in a particular situation. People in the local community who are competent and better informed about the problem than any outsider should have the responsibility of settling locally any difference of opinion.

Government Aid for Hospital and Medical Care. Basically, we should remember that we must pay for medical care. Unfortunately, the rendering of medical service becomes costly. There has been a sharp upswing in the percentage of the medical care dollar going to hospitals. Many of these increased costs are due to causes beyond the fields of medicine and hospital administration. We are living in an economic atmosphere of chronic inflation. When people have to pay for services in terms of dollars decreased in value, the cost, dollarwise, naturally goes up. We must not forget, as medical and hospital people, that this cost is not an isolated problem. It is part of the environment in which we live.

The financing of medical and hospital care can and must be accomplished. It is one of the big issues of the day. The problem needs the constructive thought of all our citizens. We need to eliminate waste. We need to become effective in helping the public, the consumers of medical care, to realize that the medical dollar can be spent wisely and that they need to be realistic about their illnesses and about their hospitalization. When they are hospitalized unnecessarily—either

by their own insistence or by their fears—they in turn increase the cost of medical care for those who are really seriously ill.

The financing of medical care must be accomplished in such a way as to impair to a minimal degree the relationship between hospitals and physicians.

We must keep in mind that fundamentally we would lose tremendously in the long run—in efficiency and in effectiveness and in the quality of medical care—if we became careless about the sources of our money. If hospital administrators, doctors and patients do not examine carefully the sources of their money and the ease with which it comes, then there is the great danger of becoming wasteful in the application of dollars in the health field, and a greater tendency toward turning to government at one level or another to finance hospital and medical care.

In other nations financing medical care by government has been expensive and inefficient compared to our methods in the United States. In my opinion, government intervention tends to be detrimental to attracting the best talent into the medical profession and the hospital field. We must not permit this to happen.

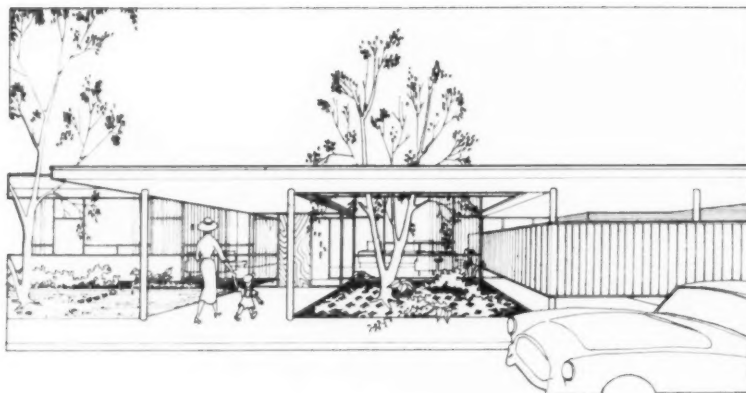
Center of Medical Culture. I look upon our nation today as the worldwide center of medical culture. Europe had that position a number of years ago, but Europe has lost it economically and philosophically, and we have seized it. We must not lose it. We are leaders scientifically. I believe we are also leaders philosophically, and we must continue to be. I know that there are people in our country who contend that assistance from governmental sources is essential. I feel that our federal government is in no condition from a financial standpoint to throw its dollars around carelessly. The government does not create wealth. If American medicine becomes dependent upon the government for financing of research, hospitals, and patient care, we can expect to be subjected to rules, regulations and controls which will ultimately affect the quality of care rendered. When the politician says, "You will operate your hospitals on a much lower budget; this is all the money that you will get," the professional people become regulated, and the effect is that you lose your initiative, and you lose your freedom. If you lose your economic freedom, soon you will lose your political freedom. I

hope that we shall be wise enough to avoid such a pitfall in the United States.

Medicare. Medicare is an attempt on the part of government to give special consideration to a group of citizens and their dependents who have been captured by the circumstances of a large armed service arrangement. However it could serve as a temptation to the bureaucrats: "We can care for this group by this arrangement; therefore, let's take in another group, and another group, and another group"—until finally the civil or lay responsibility for financing medical care is affected adversely. Let me put it this way: If we keep expanding government services, there is danger that we shall subtract the personnel and the facilities caring for the remainder of the population to a degree that the cost of care for this remainder of the population will be increased. One such instance is found in the Veterans Administration of this country. You now have recommendations for the extension of Medicare to federal employees, and recommendations for the care of the old age and dependent women's and children's groups. There is a limit to the amount of facilities which we can create and which we can afford. There is a limit to the amount of manpower—physicians, nurses, pharmacists and technicians—that we can create and maintain. If you subtract from this pool of talent those who care for government supported groups in an increasing number, you may interfere with the sound economic operation of hospitals and professional people in caring for the remainder of the population. Hence the cost per unit of care will tend to rise for civilian people.

Such an arrangement tends to divide our population into different classes of citizens. Fundamentally the American people feel that the veteran deserves every consideration for what he has done for the country, and I for one feel that he needs every medical facility and talent. But I think the vast majority of veterans want to see that all Americans have good medical care and would not want to be a party to impairing the care or discriminating against any segment of the American public.

Lay-Sponsored Hospital and Medical Plans. I believe in a free economy and in a free America, and I believe in experimentation in carrying out
(Continued on Page 106)



THE MODERN HOSPITAL OF THE MONTH

The architect's concept of the main entrance of the new Berwick Hospital, now under construction at Berwick, Pa. A color rendering of the hospital as it will look is on this month's cover.

Automat Plan Puts All Supplies in One Place

Whatever nurses need to care for their patients, from linens to intravenous trays, they will find prepackaged and ready for immediate use in the central dispatching and processing area of the Berwick Hospital, Berwick, Pa.

JANE BARTON

EVERY administrator dreams of running a hospital in which there is a place for everything, everything is in its place—and nobody wastes time fetching and carrying. Such a hospital should materialize some time late in 1958 when the new Berwick Hospital, Berwick, Pa., is ready for occupancy. It will be the result of diligent effort on the part of Gordon

Friesen, hospital consultant, and Edward Noakes, architect,¹ to design a hospital in which everything the doctor and nurse need to care for the patient is right where they need it at the time they need it.

This happy circumstance will come about with the installation of the "Automat" system of placing clean prepackaged supplies at a central point

to which employees can come and be sure of finding all the supplies and materials they need. The system is a further development of the highly successful dispatch center which Mr. Friesen worked out for the United Mine Workers' hospitals when he was senior hospital administrator for the Memorial Hospital Association of the U.M.W.² Those were multistory buildings in which the dispatcher's station was on the ground floor, and materials were distributed on wheeled carts by freight elevator, dumb-waiter and pneumatic tubes. The installation at Berwick is the first attempt to use the system in a horizontal plan, with the

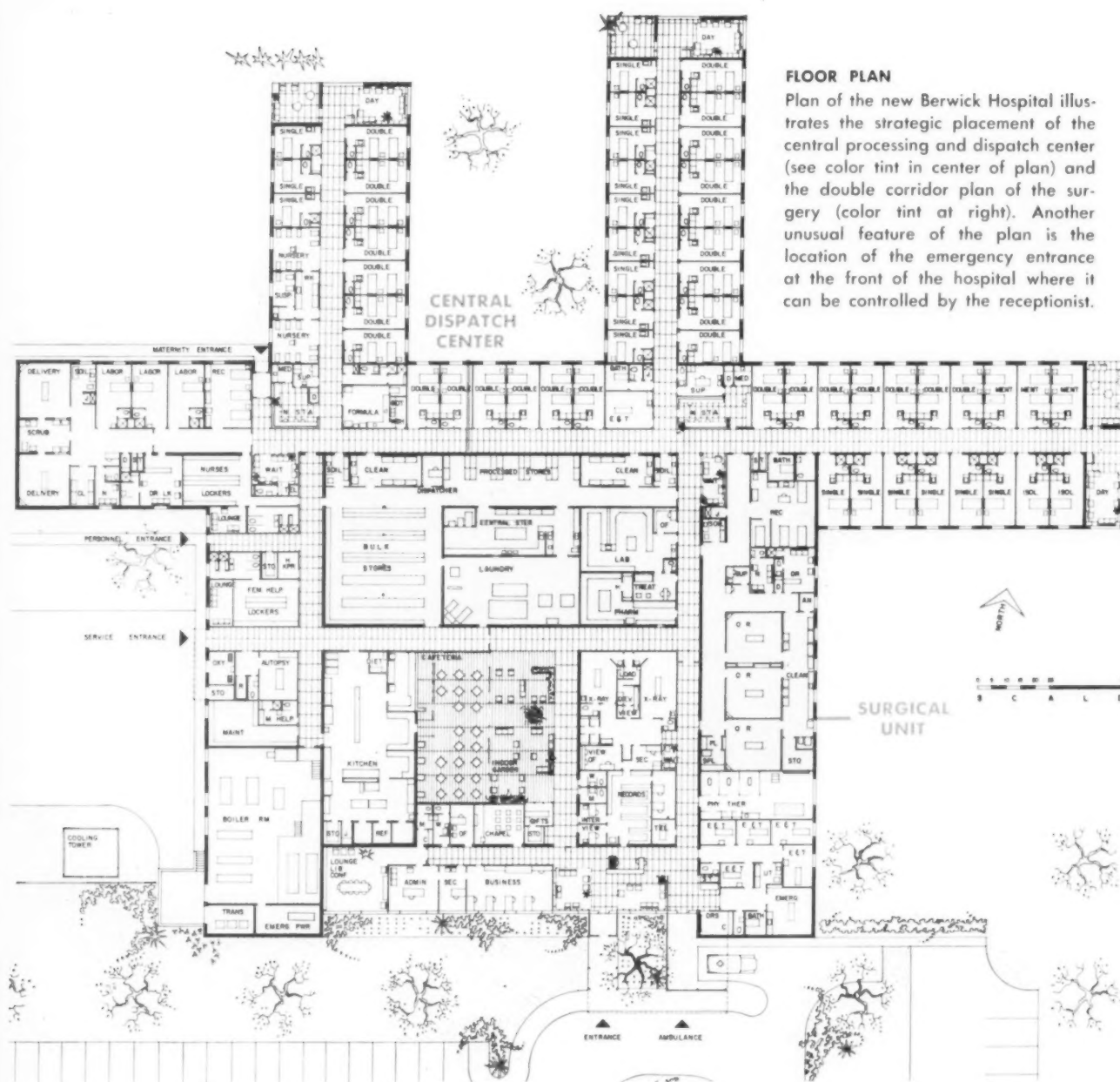
OUTLINE OF CONSTRUCTION COSTS

Total project cost (including Groups 1, 2 and 3 equipment*)	\$1,284,600.00
No. of beds.....92 (planned for 35 additional)	
Cost per bed.....	13,960.00
Total square feet..... 61,334	
Square feet per bed.... 666	
Cost per square foot.....	22.50
Total cubic feet.....734,348	
Cubic feet per bed..... 7,982	
Cost per cubic foot.....	1.53

*A good deal of Group 2 and 3 equipment is being reused from existing hospital.

¹Mr. Friesen is a hospital consultant, Gordon A. Friesen Associates, Washington, D.C., and Mr. Noakes is senior partner of Noakes and Neubauer, architects, Washington, D.C., who designed the Berwick Hospital in association with Edmund George Good Jr., architect, Harrisburg, Pa. Consulting engineers are Shefferman and Bigelson, Washington, D.C.

²See Chain Store Hospitals, The Modern Hospital, November 1953.



FLOOR PLAN

Plan of the new Berwick Hospital illustrates the strategic placement of the central processing and dispatch center (see color tint in center of plan) and the double corridor plan of the surgery (color tint at right). Another unusual feature of the plan is the location of the emergency entrance at the front of the hospital where it can be controlled by the receptionist.

dispatch center contiguous with the clean and soiled supply rooms of each nursing unit.

In the next 18 months, the staff of the existing hospital should have acquired a lot of new ideas about hospital design in relation to good patient care. They will come from Mr. Friesen who, as part of his consulting service, has undertaken to "orient the employees to the new philosophy," as he expresses it. Freely translated, this means that he will teach them how to make the best use of a production-line system of processing and dispatching supplies and equipment and how to prepackage linens,

intravenous trays, sterile supplies, and the multitude of items that must be distributed daily throughout a hospital. In short, they will learn how to save the time that is ordinarily wasted in requisitioning or chasing around the hospital in search of necessary items and spend it where it should be spent—caring for the patients.

Too few hospitals are really designed for the patient, in Mr. Friesen's view. Instead of constructing the building to conform with the organization of the hospital, hospital planners often work the other way around, he said. They build a building and expect the organization to adjust to the limita-

tions it imposes. Furthermore, he contends that too few hospital officials bother to enlighten the architect as to what actually goes on in a hospital.

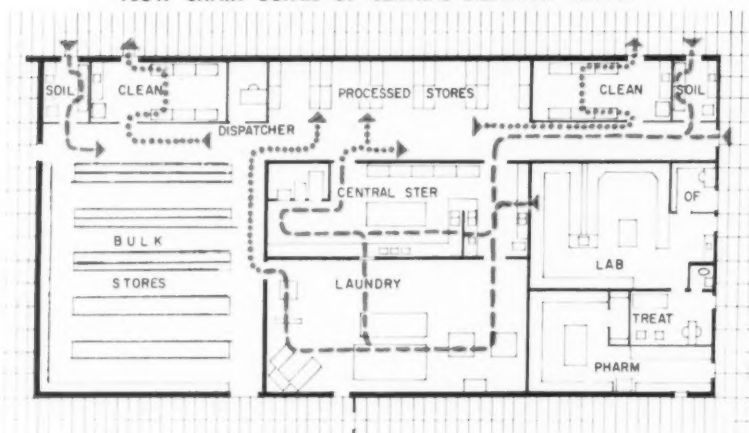
"If the administrator or the building committee will state the problem intelligently to the architect then he can give the answer to that problem in his design. The best time to do this is while we are planning the building."

In many cases the architect can't be expected to know how a hospital is operated. He can only listen to what trustees, administrator, doctors, nurses

(Continued on Page 58)

CHART SHOWS HOW "AUTOMAT" PLAN WORKS TO SUPPLY FLOORS FROM DISPATCHING CENTER

FLOW CHART DETAIL OF CENTRAL DISPATCH CENTER



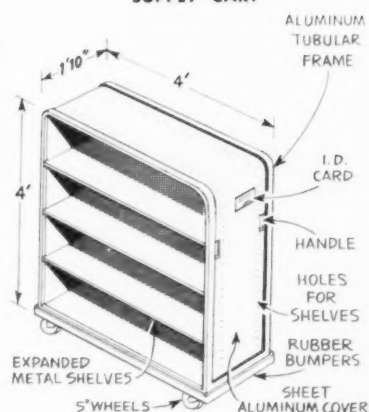
DISPATCHING. Colored lines show the progress of clean and soiled supplies from processing area to clean supply carts to floors—and the return trip of soiled articles. Clean supplies are illustrated by dotted lines and soiled items by dashes. The dispatcher's office is placed so that he is in the center of all activity in the service core. An inter-communication system connects the dispatcher with the nursing floors so that if a nurse runs short of any item she can call the service area and it will be dispatched to her immediately, thus saving her time and steps. The dispatcher assumes the responsibility for delivering and replenishing all supplies needed by the nursing and other personnel. Soiled supplies are brought back to the shelves on wheels parked in soiled supply areas.

PROCESSING. Locating the processing functions adjacent to the storage and dispatch areas makes it easy for the dispatcher to assume responsibility for delivery to and from those departments. A soiled cart returned to the cleanup side of the central sterile supply room is unloaded of everything but soiled linen which, in turn, is taken off in the receiving end of the laundry (see dash lines). Linen for sterile packs is passed through into central sterile supply at the packaging point. Processed linen is prepackaged and placed on shelves on wheels, as are processed sterile supplies which are ready for removal to the processed stores area (see dotted lines). Clean nonsterile supplies are also stored in this section. From the processed stores area complements are made up for removal on wheeled shelves to clean supply area of nursing units and surgery.

SURGERY. This double corridor operating room layout is arranged so that patients (indicated by diamond lines) are brought in one way and the surgeon, his assistant and all clean supplies come in another so that there is no cross traffic. Soiled supplies are kept out of the clean supply-scrub area. (As in diagram of dispatching areas, dotted lines show clean supplies, dash lines, soiled supplies.) The surgical patient, either routine or emergency, moves in a straight line from entrance to recovery room with everything needed for his care immediately accessible. The recovery room is located at the outer limits of the surgical area under the control of the regular nurses' station.

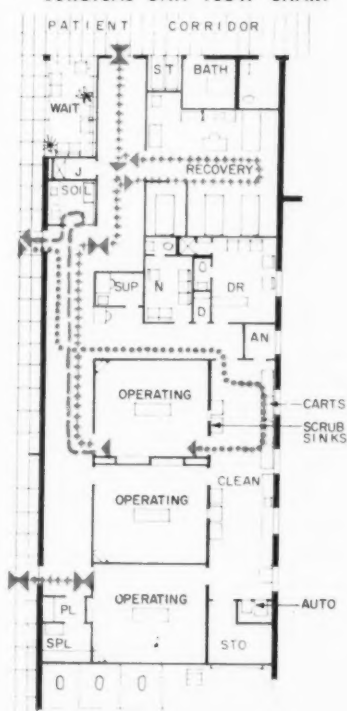
The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and state officials. A similar award will be made each month.

SUPPLY CART



Above: Drawing of the all-purpose supply cart originally developed by Mr. Friesen for the United Mine Workers' hospitals. The basic cart is so flexible that it can be used with either shelves or drawers, depending on the type of commodity to be stored or transported in it. Such carts will be kept loaded with the prepackaged complements of supplies (see lists on pages 58 and 59) in the clean supply areas, and also in soiled areas where nurses and other employees will return soiled items to be processed.

SURGICAL UNIT FLOW CHART



TYPICAL MISCELLANEOUS CART

Finger Cots.....(1 Pkg) Applicators 6".....(2 Pkg) Safety Pins #3.....(2 Doz)	Paper Drinking Cups...(1 Bx) Lubricant.....(2)	Opal Ther.....(12) Rec Ther.....(12) Bath Ther.....(1) #2 Pencils.....(6) Rubber Bands...(1 Doz)
(Shelf #1)	(Shelf #2)	(Shelf #3)
Tongue Blades.....(1 Bx) Denture Cups W/Lids..(6) 4x4 Unsterile.....(1 Pkg) 2x2 Unsterile.....(1 Pkg)	Urine Spec Bottles...(36) Sputum Cups(20)	Flexi Straws.....(1 Bx) Hoffman Clamps.....(6) Razor Blades...(1 Pkg)
(Shelf #4)	(Shelf #5)	(Shelf #6)
Drainage Bottles.....(6) Graduates.....(2)	Rubber Draw Sheets..(4)	O2 Set Up.....(1) Hot Water Btts.....(4) Adhesive Straps.....(6)
(Shelf #7)		
1/8 Brl Paper Bags.....(12) Linen Savers.....(24)	12# Paper Bags.....(12)	(Drawer) Gauze 2" & 3".....(2) Elastikon.....(2) Tape 1/2, 1, 2 & 3.....(1) Ace Band 3" & 4".....(4) Band Aids.....(1 Bx) Paper Shoes.....(10)
(Shelf #8)		

TYPICAL HOUSEKEEPING CART COMPLEMENT

Wool Blankets.....2	Bath Blankets.....4	Spreads.....4
Sheets.....4	Towel Bath...4	Pillow Case...4
Sheets.....4	Towel Hand...4	Pat. Kit.....3
Draw Sheets...4	Bed Pan.....2	Wash Cloths...4
	Bed Pan.....2	Pat. Kit.....3
		Urinals.....4
		Soap Dishes.....4
		Emesis Basins.....4
		Wash Basins.....4
Laundry Bags..2	Shower Curtains.....3	Bar Soap, Wipes, Mouthwash, Lotion, Cups
Trash Bags....2		
Mop-Heads....4		
Paper Towels..8	Toilet Tissue..10	Damp Dusters Dust Brush Temp...1
Rags in Box	Surgical Soap	Large & Small Dustpan Temp...1
		All Purpose Soap

The complement lists shown on this and the opposite pages are typical of the ones that will be attached to the sides of the wheeled carts. These were developed by Steve J. Soltis, administrator of the United Mine Workers' Beckley Memorial Hospital at Beckley, W. Va.

(Continued From Page 56)

—and anyone else who has a stake in the hospital (except the patient) tell him and do his best to bring all their ideas into a reasonably cohesive plan. Unfortunately, Mr. Noakes and Mr. Friesen agree, a plan created under such circumstances is likely to be anything but cohesive. Supplies and equipment are scattered all over the hospital, traffic lanes are tangled, and departments that are closely related as to function, such as surgery and x-ray, somehow manage to turn up at opposite ends of the building. The result, inevitably, is wasted labor time, with concomitant increase in costs, which are duly passed along to the patient.

"In most hospitals today," Mr. Friesen continued, "if the nurse on the floor wants linen, she has to get it from one source; if she wants paper towels, she gets them from another; if she wants sterile supplies, she gets them from another source again. If she wants an oxygen tent, Heaven only knows where that would be! Why do we do it? It's just tradition. There's no reason we could not have a complement of supplies ready for the nurse when she starts work in the morning to last for a predetermined period."

The plan for Berwick Hospital should achieve precisely this result. As the accompanying plan and sketches indicate, the central dispatch center includes the bulk storage area, central sterile supply, processed stores, soiled areas, laundry, laboratory and pharmacy.

Inclusion of the laboratory is logical,



Architect's drawing of the lobby and admitting area. In keeping with the consultant's and architect's thesis that patient's needs for privacy and consideration of his feelings are important in planning the hospital, the admitting area (left rear of drawing) is arranged so that the admission procedure can be carried out behind a screen. Visitors waiting in the lobby are not in a position to witness the transaction.

Mr. Friesen believes, because it obviates the need for a cleanup section in the laboratory proper. "No laboratory technician wants to do laboratory cleanup work anyhow. So we just put the laboratory next to central supply with a pass-through window between them. As soiled glassware and other articles accumulate, they can be moved directly into central supply for cleaning," he explained.

The key to the dispatching center, and to the success or failure of the whole system, will be the dispatcher who will probably work under the supervision of the pharmacist. It will be the dispatcher's job to receive and distribute all supplies, from the time they are brought into the bulk storage area until they are processed, packaged and put on wheeled carts lined up in the processed stores section adjoining his office.

From these carts, other carts or shelves on wheels will have their complement of prepackaged supplies made up and delivered to the clean supply areas of the hospital on schedule. The complement for each cart and its delivery schedule will be worked out by a procedure committee consisting of representatives of the nursing department and medical staff.

The distribution system will work like this: When a nurse is preparing to give morning care, let us say, she goes to the clean supply room (see plan, page 56) and obtains the trays she needs—intravenous, dressing or whatever is required—without having to requisition them or travel to central supply or the pharmacy to get them. In case she runs short of dressings or medications while she is caring for the patient, a call to the dispatcher on the intercommunication system will bring the missing article by messenger.

Reversing the procedure, the nurse will return soiled supplies to a cart in the soiled supply room. When the cart is filled it will be taken by the dispatcher to the processing core where the soiled articles will be removed, processed, repackaged and replaced on a clean truck in the processed stores area, ready for distribution again.

The same procedure will be followed by housekeeping employees who will find carts loaded with the day's supplies ready for them each morning. This same system works in all other areas in the hospital where supplies are used, such as the operating suite, the delivery suite, and the nursery.

TYPICAL INTRAVENOUS SOLUTION CART

Intravenous Trays.....3		Safisect # 800-25.....9	
		Safifilter # 804-18.....8	
		Saficlysis # 807-11.....8	
		Safifilter "Y" # 810-14.....8	
		Comb. Pump & Adm. Set Baxter R48..4	
Dextrose 5% in Water—1000 CC...4		Normal Saline. I.V.—1000 CC.....4	
Dextrose 5% in Water— 500 CC...4		Normal Saline. I.V.— 500 CC.....4	
Dextrose 10% in Water—1000 CC...4		Dextrose 5% in Saline—1000 CC...4	
Dextrose 5% in Ringers—1000 CC..4		Dextrose 5% in Saline— 500 CC.....4	
Amigen (C.P.H.)—1000 CC.....8		Invert Sugar Electrolyte # 2-1000 CC..4	
Ringers Solution—1000 CC.....4		Invert Sugar Electrolyte # 3-1000 CC..4	
Lactate Ringers—1000 CC.....4		Dextrose 10% in Saline—1000 CC...4	
Invert Sugar Electrolyte—1000 CC...4			
±1			
Furacin Sol. 1-6000.....4		Dextran 6% in Normal	
Normal Saline External.....4		Saline—500 CC.....4	
Distilled Water—External.....4		Arm Boards	
Sodium Lactate M/6—500 CC.....4			

TYPICAL STERILE CART, POSTPARTUM

Catheters, Foley, 16. 1 Ea.	Cotton Balls, Cons.....2 Ea.	Per Pads.....60 Ea.
Catheters, French, 16. 1 Ea.	Cotton Balls, Pkg.....2 Ea.	
Catheters, Nasal, 12. 1 Ea.	Sterifile, 2 & 5 CC.....1 Ea.	
Sponges, 4 x 4.....6 Ea.	Uterine Forceps.....1 Ea.	
Sponges, 2 x 2.....6 Ea.	Syringes, 50, 20, 10, TB	
A.B.D. Pads.....6 Ea.	Syringes, U-40, U-80...1 Ea.	
Vaginal Packing...1 Ea.	Syringes, 2 & 5 CC.....2 Ea.	
	Medicine Droppers.....1 Ea.	
Perineal Trays.....3 Ea.	Culture Tube W/App...2 Ea.	
Clip & Suture Trays...1 Ea.	Needles, 20, 22, 1".....2 Ea.	Gloves, 6 1/2, 7. 2 Ea.
Vaginal Cotton...4 Pkg.	Needles, 18, 20, 1 1/2".....2 Ea.	Gloves,
	Needles, 25G, 3/8".....2 Ea.	Rectal, 7 1/2...3 Ea.
Catheter Trays.....2 Ea.	Vaginal Prep Trays.....3 Ea.	
Enema Trays.....4 Ea.	Regular Prep Trays. 3 Ea.	Rectal Exam Trays...3 Ea.

TYPICAL LINEN CART—ADULT

Bed Spreads...15	Towels—Bath...20	Pajamas.....12	Trash Bags.....00
Sheets.....20	Towels—Face...20	Bath Robes....10	Blankets—Bath.. 6
Sheets—Draw...20	Wash Cloths...20	Laundry Bags...10	Patients' Gowns. 20
			Pillow Cases...20

The complement lists that will be attached to each of the carts will be worked out by the members of a procedure committee which will include representatives of the nursing department and medical staff.

Even though the system revolves around the wheeled carts, Berwick Hospital's corridors are not going to be cluttered with "little men running up and down with trucks," Mr. Noakes explained. Except for an occasional nourishment cart and the operating room carts, which will be moved at night, the movement of supplies and equipment will be confined within the limits of the dispatching-processing area where they present no traffic hazards.

GROUPING OF SERVICES

Not only supplies but people and services should be grouped in logical and orderly fashion, Mr. Friesen and Mr. Noakes believe. To this consult-

ant and architect there appears to be little purpose in separating departments that really belong together, like emergency room, operating room and x-ray, or admitting office and medical records, just because it is a tradition.

Putting the ambulance entrance around at the back of the hospital is a pet source of irritation to Mr. Friesen. So, with Mr. Noakes' enthusiastic cooperation, the ambulance entrance at Berwick has been moved to the front, leading directly into the emergency room which, in turn, is accessible to both the operating rooms and the x-ray department. It is also under the observation of whoever is on duty in the lobby. "That's where the emergency entrance belongs," said

Mr. Friesen. "What good does it do a patient to be brought in at 3 o'clock in the morning and find the emergency door locked, with no one around who knows what to do for him? The receptionist, in the daytime, or the telephone operator, from midnight on, should control both the lobby and the ambulance entrance so that at a moment's notice she can make sure the patient is looked after." Although the receptionist can see the ambulance entrance, other patients and visitors cannot. The lobby is designed to shield them from unpleasant sights or sounds.

Directly behind the admitting desk lies the medical records room—and behind that is the x-ray department. Placing records between admitting and x-ray (which is also strategically placed in relation to surgery) seems the most sensible arrangement possible to Mr. Friesen. "Who has more interest in the admitting procedure than the records clerk? And who is better suited to fill in on the reception desk when the admitting clerk is off duty than the person who will ultimately be responsible for the patient's record? That's why we put records contiguous with the admitting desk. And since x-ray films are part of the

patient's record, it is just as logical to have the x-ray department and records close together." This also enables the x-ray secretary and record clerk and the medical secretaries to fill in for each other during vacations, illness or even lunch periods.

DOUBLE CORRIDOR SURGERY

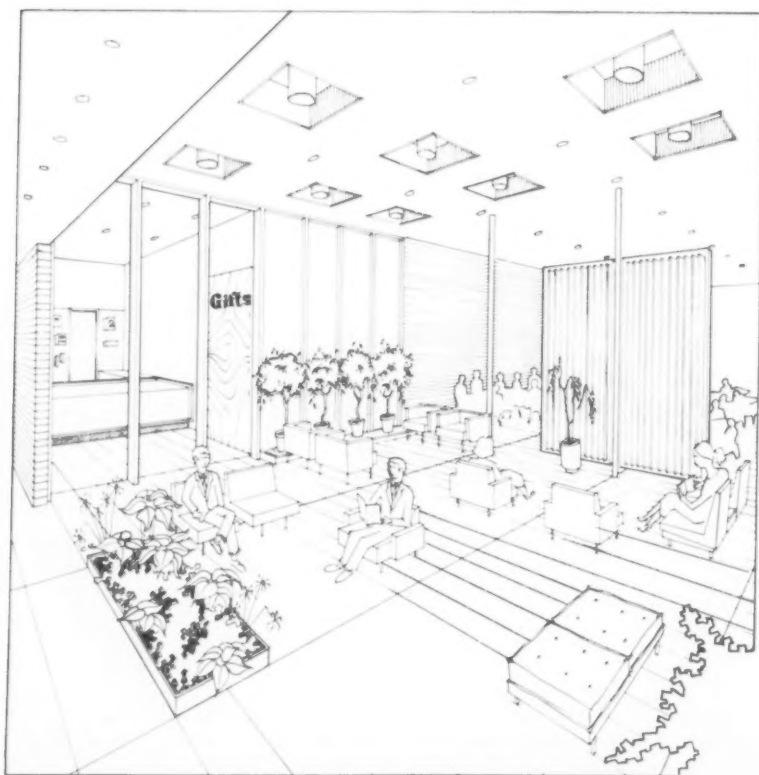
The double corridor operating room layout epitomizes Mr. Noakes' and Mr. Friesen's mutual determination to keep things together that belong together—and keep everything else out. Entrances to the operating rooms are so arranged that patients are brought in one way and the surgeon, his assistant and all clean supplies come in another so that there is no cross traffic. Soiled supplies are kept out of the clean supply-scrub area.

The surgical patient, either routine or emergency, moves in a straight line from entrance to recovery room, with everything needed for his care immediately accessible. The recovery room is essential in every hospital, no matter how small, Mr. Friesen believes. To be practical, it will be at the outer limits of the surgical area, under the control of the regular nurses' station, so that it can be used for other purposes if necessary.

The new building, to be constructed of load-bearing masonry with plaster interior, is designed for 84 beds, expandable to 92 in case of need. Some day it is expected that another wing will be added at the east end of the building.

The hospital will be completely air conditioned. Nurses' stations will be connected by intercommunication system with patients' rooms and also with the dispatcher's station. The mechanical and electrical contract amounts to a little less than 50 per cent of the construction costs. This figure indicates "the completeness of the mechanical features of the hospital plus remarkable economy of construction," Mr. Noakes reports. He estimates that the final cost of the project is expected to be \$22.50 per square foot, including all equipment.

Economy will be the word for the Berwick Hospital, Mr. Friesen believes—economy of construction, of operation, of materials and labor. "Based on the same standard of care given in hospitals that cost much more to construct, we believe this hospital will cost 15 per cent less to operate and the nursing time available for direct care of patients will be increased 25 per cent."



Beyond the main lobby, and located adjacent to the cafeteria, visitors and patients will find an indoor garden, as illustrated in this drawing. The gift shop will also be handy to this area. Walls here will be brick and plaster, and the flooring, asphalt tile. Lights will be recessed.

What Makes an Internship Desirable?

The prospective intern wants both good teaching and a chance to gain experience, this study indicates, but if he can't find both in one hospital, and the quality of teaching is about equal, his choice is likely to be the charity hospital where he can be "on his own"

WILLIAM H. HARRISON Jr. and IRA O. GLICK

WHAT the medical student desires from the average hospital for internship and what the hospital has to offer do not coincide. When choosing a hospital for internship, the young medical student looks for good teaching and also for the experience and responsibility that will be available to him. This finding came to light in a study that sought to answer the question: "What factors are involved in the young medical student's final internship decision?"

Then, because they associated certain of these factors in varying degrees with specific hospitals, these young students tended to choose that hospital which best met the standards they have set for themselves and their future. This answer was the result of the question: "What attracts the medical student for internship in a specific hospital?" Since the quality of teaching in the various types of medical school-affiliated hospitals we studied, in the main, is viewed as pretty much the

same, experience and responsibility, often associated with public or charity hospitals, assumes a major importance.

Although there would probably be some disagreement as to the underlying factors involved, almost every hospital administrator must be aware of the yearly problem in filling his allotted internship positions. The problem to which our research was directed was to investigate the factors of paramount importance for the medical student in choosing a hospital in which to serve his internship.

This study, carried out by the authors while they were both at Social Research, Inc., actually proceeded in two stages. The first of these consisted of personal interviews with 24 members of the senior medical school class, randomly selected from the class roster of a metropolitan university. These hour-long interviews were general in character, the respondent covering his personal and family background, his reasons for entering medicine and the

Medical School, his present feelings about the school and its affiliated hospital, and his plans for the future, including choice of hospitals for internship.

From information acquired in the interviews, specific hypotheses were outlined and a more structured, standardized questionnaire was developed. The latter was mailed to all junior and senior medical students at ——— Medical School, yielding a return of 53 per cent, or some 119 mail responses. These, together with the 24 depth interviews, form the basis of the material analyzed for this report.

In general, career decisions are almost always difficult to make. Their

implications for the future are extremely important and, at the same time, often difficult to assess. Once a decision is made it may dictate succeeding moves that are often beyond the control of the individual. The selection of a hospital for internship is certainly no exception to this general observation. There are so many factors involved for the average medical student that it is safe to say it is one of the more important and complex decisions in his medical career. Facts from his own background and present position, as well as ideas and plans for the future, impinge upon the all-important decision. Most medical students look upon the year of internship as a significant roadmark in the total career pattern in the medical field.

That the opportunity to make this decision is generally looked forward to is not surprising, for the internship is somewhat of a "rite de passage," signifying the attainment of a new status, one with full colleagueship and professional standing in the medical fraternity. To attest to the importance of the change is a great backlog of time, energy and money invested in training and preparation.

That the opportunity to make the decision is accompanied by a good deal of anxiety is also to be expected, if only because of the implications for the future. This, in itself, helps explain why the internship decision is typically approached with care and caution, and only arrived at after the many factors involved are thought about, discussed and evaluated.

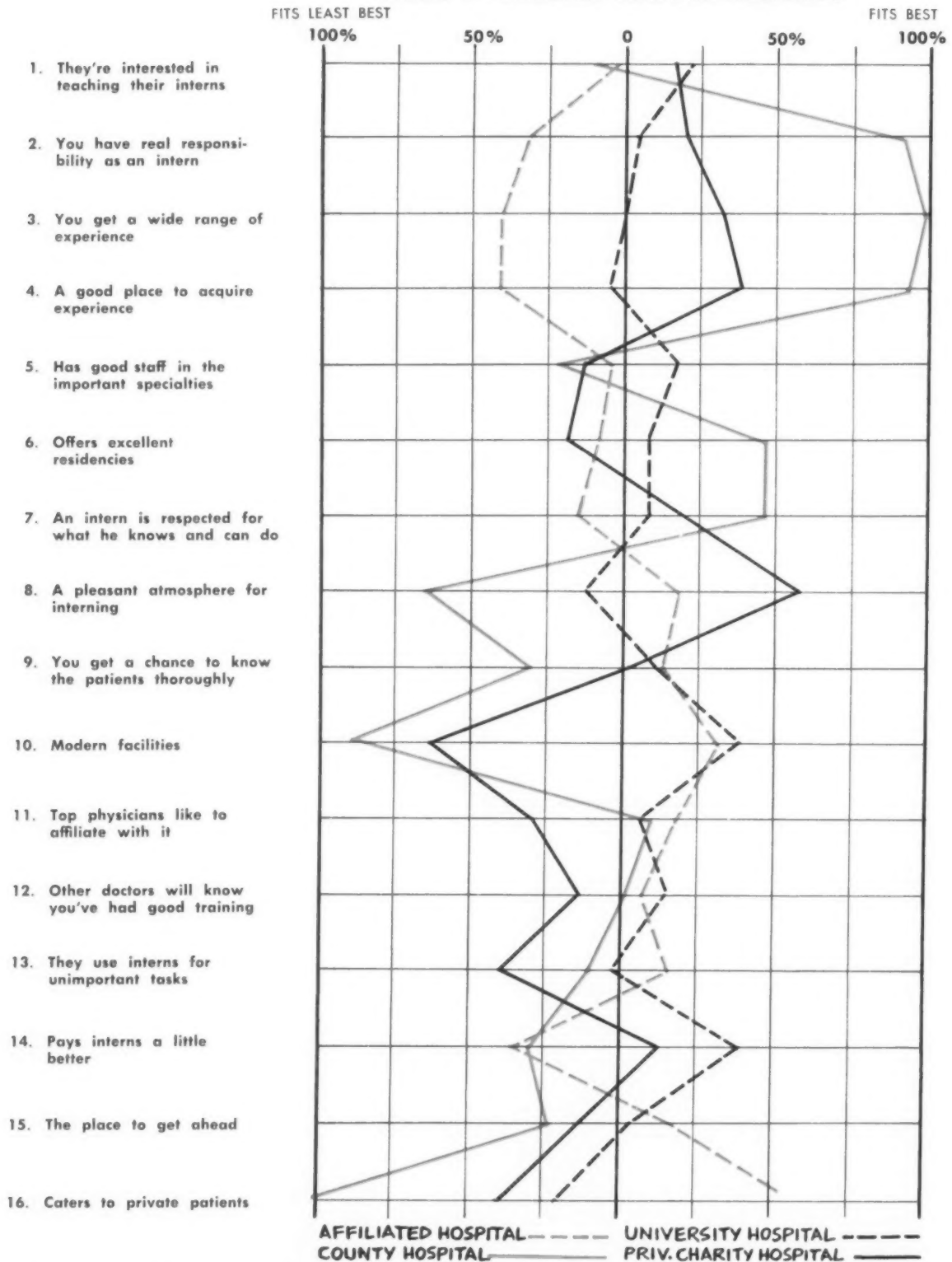
This, then, would seem to be the first of other contradictions and dilemmas.
(Continued on Page 63)

Mr. Harrison, who was associated with Social Research, Inc., during the study described in this report, is now a management consultant with his own firm of W. H. Harrison Jr. and Associates. He has had experience with various hospitals in the latter capacity. He is also teaching courses in human relations and management problems at Illinois Institute of Technology.

Ira O. Glick is a project manager at Social Research, Inc. He obtained his M.A. degree in sociology at the University of Chicago in 1951, where he is currently completing his Ph.D. program. He has participated in and supervised a variety of research projects, ranging from consumer motivation to industrial and hospital organizational studies.

The authors are indebted to Dr. Lee Rainwater of Social Research, Inc., for the development of the questionnaire, and Rudolf K. Haerle Jr. for help in the preparation of this article.

Profile I—ATTITUDES TOWARD HOSPITALS



Students compared four representative types of hospital (county, university or teaching, private with large percentage of charity patients, and the medical school's affiliated private hospital) in relation to 16 items. Although teaching was found to be the single most important

factor to the students, they made little differentiation among the four in rating the quality of teaching in each. As far as experience and responsibility were concerned, however, the ratings given the four institutions showed striking variation, with the county hospital rated highest.

(Continued From Page 61)
 mas that emerged from our research. The individual medical student is both eager to make the decision and gain his new status, and yet extremely anxious and hesitant about it because of the ever present possibility of making a mistake that could negatively affect his career. To meet this dilemma and overcome it, the average medical student must think out and evaluate those factors which are pertinent to his own situation, those which are most meaningful to him and the way he perceives his future career.

In evaluating the various factors associated with the decision to join a hospital for internship, certain types emerge from our analysis that help to clarify the pertinent findings.

Briefly, the factors involved can be divided into two groups: those of a general nature, which seemingly affect all medical students in more or less the same form; and those which are essentially individual, affecting each student in a rather unique way,

and are dependent upon his own, particular situation. Because the general factors have greater applicability for the larger group of medical students in the United States, they will form the major part of the discussion in this report.

How Students Rank the Factors That Affect Their Selection of Hospitals for Internship

INFORMATION obtained during the depth interviews led to the setting up of a list of 16 statements, these ideas relating to aspects of the internship situation felt to be relevant to

hospital choice. These statements were taken directly from the interviews themselves and represent those items most often expressed by these medical students. The students were asked to rank these 16 statements in the order of their importance, to them, as factors in the selection of a hospital. Table 1 summarizes the findings, based on the percentage of the total sample of the students that rated each factor as being of prime importance or at least among the top three most important factors.

It can immediately be seen that the first four factors listed stand out from all the rest. Actually we feel that they represent the two main dimensions of the intern situation. The first statement, dealing with the hospital's teaching status, is the most important single factor to these students. Some 55 per cent indicate it to be their first choice, and 87 per cent rank it among the top three most significant items of the 16 presented.

The second dimension, that dealing with the experience-responsibility aspect, is made up of statements 2, 3 and 4. When taken together, 33 per cent feel they form the single most important factor on the list. Somewhere close to half feel that each statement individually ranks among the first three factors of importance.

Generally speaking then, there are two important factors or clusters of factors in the selection of a hospital for internship; and as seen by medical students, the two, when taken together, constitute a dilemma. The single, most important factor that emerged was the desire for continued excellent teaching.

"I was interested in finding a hospital where they had excellent teaching facilities, that's why I'm going to ——. It has a full-time attending staff. My feeling is that I would like

Table 1—FACTORS IN HOSPITAL SELECTION

	Percentage of Seniors and Juniors Selecting Item for 1st Position of Importance	Percentage of Seniors and Juniors Selecting Item for 1st, 2d or 3d Position of Importance
They're interested in teaching their interns	55%	87%
You have real responsibility as an intern	12%	46%
You get a wide range of experience	10%	55%
A good place to acquire experience	11%	39%
Has good staff in the important specialties	2%	22%
Offers excellent residencies	4%	13%
An intern is respected for what he knows and can do	2%	12%
A pleasant atmosphere for interning	1%	5%
You get a chance to know the patients thoroughly	1%	4%
Modern facilities	—	3%
Top physicians like to affiliate with it	—	3%
Other doctors will know you've had good training	2%	5%
They use interns for unimportant tasks	1%	2%
Pays interns a little better	—	5%
The place to get ahead	—	—
Caters to private patients	—	—

Students were asked to rank these 16 statements in the order of their importance to them as factors in the selection of a hospital. This table summarizes the findings, based on the percentage of the students who rated each factor as being of prime importance or in the top three most important factors.

to spend a year's time learning more. I know there's a lot more that I could learn, and I'd say that most of my classmates feel the same way. This isn't true only of ——— students; it's true of most of the senior medical school students that I've come in contact with."

In brief, the hospitals which offer what is felt to be the best teaching program and faculty are most desirable.

Although this research was not concerned with the students' definition of "good teaching," it is our impression that they implied a certain personal identification between student and teacher. In the relationship, the student wants to feel that the teacher is interested in him and concerned with his progress. At this stage of research, we can only label this as a subjective conclusion; certainly it is an area for further research.

Opposed to this attitude is the general desire to acquire a variety of medical experience and have responsibility for the treatment of patients.

"I want a charity hospital (for interning) primarily because the large part of my training has been in a private hospital. I feel I'd like to make some of my own decisions. I learn more when I have a problem to solve and a problem that is my own. In a private hospital the intern has few chances; actually, you're acting like a machine in somebody else's hands. I've talked to a lot of interns at private hospitals, and have been able to observe how it works out for them. I want to have the feeling that I'm not intruding when I go into a patient's room; instead, I'll have the feeling that the patient is mine. If the patient is cured or helped, it's me, and I won't be just a slunk."

The ideal hospital for internship would be a combination of these two aspects. If the young intern felt that he would have available the excellent teaching facilities of a highly competent staff of doctors, as well as the opportunity to gain valued medical experience by being responsible for the care and treatment of patients, he would most certainly desire a position at that hospital for his internship. However, there is a general consensus within this group that such an ideal hospital is not available, necessitating in its stead a choice between one of the two alternatives: teaching or experience-responsibility.

Students Must Decide Which They Want Most: Good Teaching Programs or More Experience

ALTHOUGH the solution to this dilemma may seem to be an objective matter, choosing between a "teaching" hospital and an "experience-responsibility" hospital, it may be that the situation is better described in terms of an underlying, subjective pattern. The rôle of the student is clearly distinguishable from that of the practitioner, and this is especially true in the case of the medical student and the practicing physician. The aspiring intern is possibly beset by a conflict in these two rôles. He may desire to prolong his student rôle and, at the same time, yearn to begin his active rôle as a doctor, both diagnosing and treating the patient. This, then, would seem to be the subjective dilemma underlying the more objective situation outlined previously.

Most freely admit that they do not feel fully qualified to assume the position of doctor. While they feel that

their training has been satisfactory, they are not convinced it has been adequate. They believe they have much more to learn, and it would therefore be advisable to extend their learning period for an additional year. Hence, the desire to intern at a "teaching" hospital. The importance attributed to the teaching factor suggests the partial, and subjective, desire to remain in the rôle of medical student, rather than to accept the full responsibilities associated with the rôle of doctor.

At the opposite pole is the desire to act out the rôle of the doctor, gaining practical experience in administering to the sick by having the position of direct responsibility. Associated with this attitude is the idea that, after a prolonged period of training and schooling, there is an impatience to assume the position of responsibility and all that it entitles the holder—to be a full professional, to be treated and

Table 2—FACTORS IN HOSPITAL SELECTION

	1st Position of Importance		1st, 2d or 3d Position of Importance	
	Srs.	Jrs.	Srs.	Jrs.
They are interested in teaching their interns	61%	43%	91%	78%
A good place to acquire experience	7%	17%	33%	48%
You get a wide range of experience	9%	17%	49%	63%
You have real responsibility as an intern	15%	7%	52%	37%

The emphasis on teaching and on experience-responsibility as factors in hospital selection for interning becomes more understandable when students discuss their feelings about graduation from medical school, their past experiences in hospitals, and their conception of the graduate doctor rôle.

Most freely admit that they do not feel fully qualified to assume the position of doctor, that while their training has been satisfactory (and that the university is one of the top medical schools in the country), they are not convinced it has been adequate.

Teaching is ranked as most important by 61 per cent of the senior medical students who were queried, while only 43 per cent of the juniors give it first rating.

to have the opportunity to act as a doctor. We are told by quite a few students that the desire to be more assertive in the professional rôle is one reason for going to a hospital where the intern is given responsibility, as well as to leave the hospital where the new doctor, in the rôle of intern, is known as a recent graduate of the affiliated school. Full collegue-ship, and the subjective feelings which accompany it, is difficult to achieve in a situation where the intern is known as a former student.

When we view the top four factors, dealing with teaching, experience and responsibility, and break them down by class, we find an interesting pattern to support our idea of the subjective dilemma of the student rôle *vs.* the doctor rôle. (See Table 2.) Both juniors and seniors feel that teaching is the most important consideration. Yet the seniors, actually completing their formalized teaching, are more concerned with their own lack of knowledge and have greater desire to continue the teaching relationship during the intern period than do the juniors. Of the seniors, 61 per cent rank teaching as the most important consideration, while only 43 per cent of the juniors do likewise.

JUNIORS WANT EXPERIENCE

The figures on "experience" indicate another facet of this dilemma. The juniors seem to show a certain impatience to acquire greater experience. They are less concerned about teaching than are the seniors. They seem to be saying that they are learning all they can from the books but now they need experience.

On the other hand, the seniors, approaching the functional rôle of the doctor, are not as confident of their knowledge. They indicate more anxiety over the thought of practicing "where it counts." They have less desire for experience, realizing that it will be part of the intern rôle, and greater concern with teaching standards. They seem to be saying that it would be best to acquire a little more knowledge. Yet evidence of the subjective dilemma shows up when we see that some also desire greater responsibility.

To sum up this point: The subjective dilemma of wanting to assume the functional rôle of the doctor, and yet desiring to extend the student rôle, would seem to be closely related to, if not directly underlying, the objec-

tive dilemma of the "experience-responsibility" hospital *vs.* the "teaching" hospital, found to be so important to these medical students. To resolve this

dilemma, the individual student must assess his own situation in the light of the factors meaningful to him and make his choice.

Charity Hospitals Have an Advantage in Terms of Experience-Responsibility Offered Students

BECAUSE the majority of these medical students perceive this as a situation with two opposing alternatives, it is only natural that they come up with a corresponding dichotomized typology of hospitals. They would prefer to intern at a hospital which would permit them to extend their student rôle for an additional year, and at the same time offer them the responsibility of the full-fledged physician. But they see these two, at least in part, as contradictory. Instead, they are likely to see the conflict in terms of what various types of hospitals offer the intern, and easily categorize hospitals into two groups—those which they believe emphasize the teaching aspect of the internship and those which emphasize the responsibility-experience dimension. Generally speaking, the former are private hospitals,* while the latter are charity or public hospitals. When asked to rate private *versus* charity hospitals in terms of their re-

spective advantages and disadvantages for internship, several main themes were mentioned as shown in the table at the bottom of the page.

However, our data would seem to indicate that the choice of hospital types is not so complex. Because most feel that the quality of teaching is approximately the same in the types of hospitals we studied, and because of past experiences during the clinical years of their medical training, they are inclined to solve the dilemma by choosing those hospitals which offer the opportunity to gain experience and responsibility. As has been discussed, this results in greater choice of the public, or charity, type of hospital. They tell us their primary reason is that, while teaching in private hospitals is usually better than in charity hospitals, it is not good enough to compensate for the lack of responsibility and experience. This impression is based on their clerkship experiences, conversations with other interns, and hearsay filtering through the "grapevine"; that it is not developed solely

*We do not differentiate here between voluntary and proprietary hospitals, but pose "private" opposite "public" based on the type of patients involved.

ADVANTAGES AND DISADVANTAGES OF PRIVATE AND CHARITY HOSPITALS

CHARITY	PRIVATE
Advantages:	Advantages:
More responsibility.	Teaching is better.
More experience.	Learn correct technic.
Feeling of being the doctor.	Learn art of medicine.
See and do more; wide variety of cases; more active in care of patient.	More like typical practice.
Disadvantages:	Disadvantages:
Do not learn art of medicine.	Less experience.
Much different from typical private practice.	Less responsibility.
Supervision not adequate.	Smaller work load in the sense of minimum responsibility.

When students were asked to rate private versus charity hospitals in terms of their respective advantages and disadvantages for internship, the factors shown here were mentioned as being of special importance to them.

from their own direct experience, or attached to their school's affiliated hospital, is also clear. They feel this is true of all private hospitals.

That the experience-responsibility theme is important for them is best understood when the students talk about the clinical years of their medical training and when they generally refer to the many years they have been students. The majority point out that they received training in private hospitals whose typical patients are higher status individuals. They further state in this connection that the patient's private doctor has the sole responsibility and duty, and rightly so, to care for the patient. Nevertheless, this means that clerks and interns, because of the type of hospital and nature of the patient as to status, have virtually no opportunity to acquire experience or to assume the responsibility they feel is required to become a competent doctor. Having lived in this system, they realize its drawbacks. For many students, this implies that an internship at a hospital which attracts lower status patients, preferably a charity hospital, would be more beneficial to their careers.

To get a clearer picture of this situation, we asked these students to compare four representative types of hospitals in relation to the 16 items previously mentioned. For each statement they were asked, "Which two (of the above hospitals) fit the statement best?" and then, "Which two fit the statement least best?" By subtracting the negative from the positive votes, it was possible to arrive at the respondents' judgment of each hospi-

tal. Included were a county hospital; a university or teaching hospital; a private hospital with a large percentage of charity patients, and the—Medical School's affiliated, private hospital. Each of these hospitals had some form of teaching available, ranging from a full-time teaching staff to various types of part-time teaching arrangement. The resulting profiles were indicative of the foregoing discussion. (See Profile I, p. 62.) Although we had found teaching to be the single most important factor to these medical students, we found very little differentiation in the rating of the teaching factor at these representative hospitals. In their eyes, there was almost no difference in their teaching potential, the status of this dimension remaining pretty much in the neutral zone. All four rated between the -12th to the +22d percentile.

CHARITY HOSPITALS RATE WELL

In contrast, what emerges from a further comparison of the four curves is the striking differentiation for the items pertaining to the experience-responsibility factor. The county or charity hospital receives a very high positive score around the 80th to 95th percentile, while the affiliated private hospital receives a low, negative score. The other two hospitals fall midway between these two extremes.

The over-all similarity of these different hospitals for the teaching factor, as contrasted with the wide differences along the experience-responsibility theme, indicates why many students resolve their dilemma in the direction of the charity hospitals.

his financial needs and obligations. Two additional research findings, essentially unrelated to student attitudes toward types of hospitals, are worthy of mention, as they indicate the fertile nature of this area for future research. One has to do with the marital status of students. From what these people say, it is clear that the wife often has considerable influence in the internship decision, not so much as to the specific hospital selected, but rather the part of the country in which it is located. This may be due to her desire to be near home or their combined desire to "visit" a new part of the country. The implications of this for affiliated hospitals is that another individual enters the decision making process. It must also be kept in mind that this second individual has minimum contact with and knowledge of the hospitals. Hence, she is less concerned with the type of intern program offered and more concerned with geographic location.

The second unrelated finding concerns the potential intern ratio for various geographic regions of the U.S. On the basis of the student's home and where he plans to practice, it was found that certain areas may lose many potential doctors. The general trend seems to be westward, to the Mountain and Pacific states. Closely related to this is the notion that it is desirable to intern in the area where one plans to practice. If an area does not retain "its own" students in terms of where they will eventually practice, then in all likelihood the area must lose, for interning purposes, some who plan to move away.

Summary

The research shows there are two main considerations which students take into account when selecting a hospital for internship. One refers to the teaching of interns and the other to the intern's opportunity for experience and responsibility. Underlying this is the subjective dilemma of wanting to extend the student rôle and yet desiring to function actively in the physician's rôle. The various types of hospitals we studied do not differentiate to an appreciable degree on the teaching factor, but charity hospitals are seen as giving the intern much greater responsibility and experience than private hospitals. For many students, this is one of the main reasons for preferring a charity hospital over a private hospital.

Individual Factors, Such as Housing, Stipend or Hospital Reputation, Also Influence Choice

BECAUSE we have stressed the wider applicability of the general factors does not mean we deny the relevance of many individual, unique factors. For any one student making a decision, a single, unique factor may be of paramount importance. Stipend, student housing, hospital reputation—all these may be important as unique influences upon an individual. But what we are saying is that the individual factors are of lesser importance. A correct

interpretation is that, in comparison with other factors, these individual factors are relatively less important in the selection of a particular hospital for interning. They include such things as the social and professional aspirations of the medical student, his plans to practice in a particular section of the country, his (or his wife's) desire to intern closer to home, his feelings about interning in a particular kind of hospital environment, and, finally,

Impact of Heart Surgery on Hospitals

Beginning a series of articles on the development of cardiovascular surgery and its impact on planning, equipping, staffing and administering the operating room floor and the special needs of the patients

HERSCHEL E. MOZEN, M.D.

THE human heart is a mass of specialized muscle which weighs about three-quarters of a pound. It is essentially a hollow four-chambered pump with a simple system of valves that provides for the ingress and forceful outward propulsion of blood. Although the heart is a simple anatomical structure its function is complex and in many ways still mysterious. We do not know what vital forces cause the fusion of the primitive blood tubes within the early developing fetus nor why the resulting mass of myocardial tissue should develop and maintain the specific quality of autonomous contractility for a lifetime. The anatomy of the heart and its conduction system is well known. The presence of a cardiac pacemaker (sino-auricular node) along with a system of specialized conduction tissue (auriculo-ventricular node, bundle of His, right and left bundle branches) has been verified and studied. We can classify and treat various derangements of the orderly heartbeat, but we still are unable to explain the fundamental cyclically recurring series of biochemical reactions which initiate the contractile impulse within the cardiac pacemaker.

From the department of surgery, Western Reserve University School of Medicine and the University Hospitals of Cleveland.

Dr. Mozen is chief resident in thoracic surgery, Sunny Acres Hospital, Cleveland.

The second article in this series, which will be presented in the November issue of this magazine, will deal with the problems of cardiac arrest.

Although many areas of investigation still are to be clarified, tremendous and almost unbelievable strides have been made in the surgical treatment of heart diseases within the last decade. The heart has been the last great challenge to the surgeon's skill. In spite of a stubborn resistance it now has entered fully into the domain of operative therapy. The historical development of new and better technics along with the story of the men who made these advances is a fascinating chapter. It should be of interest to all who are concerned with the care of sick patients.

Physicians of old, and indeed as recently as the late 1800's, regarded the heart as a sacred organ. They imbued it with a mysterious delicacy which somehow rendered it inviolate to manipulation. Wounds of the heart were rather common in ancient times. Various observers noted that these wounds were almost invariably fatal. Rapid death following the removal of a weapon from the heart is depicted by the fate of Epaminondas at the battle of Mantinea in 363 B.C.: "At last while he was most heroically exerting himself to gain the victory for his country he received a mortal wound in his breast by a dart thrown with such force that the wood broke and the iron remained in his body and he fell to the ground. And Epaminondas, yet living, was brought to the camp; and when the physicians that were sent for told him that he would certainly die as soon

as the dart was drawn out of his body, he was not at all daunted; but first calling his armour-bearer he asked whether his shield was safe. The armour-bearer said it was and showed it to him. Then he inquired which side had won the day. The youth made answer that the Boeotians were the victors. 'Why then,' said he, 'now is the time to die,' and forthwith ordered the dart to be drawn out, and so upon the drawing out of the head of the dart, he quietly breathed his last."

Extreme pessimism continued to cloud observations concerning wounds of the heart for many centuries. Most surgeons felt that wounds or incisions of the heart would not heal after suturing because of the continual contractions of the myocardium. In fact, such a daring surgical pioneer as Billroth wrote in 1883, "A surgeon who would attempt such an operation (cardiac suture) should lose the respect of his colleagues." In 1896, Paget wrote, "Surgery of the heart has probably reached the limits set by nature to all surgery; no new method and no new discovery can overcome the natural difficulties that attend a wound of the heart. It is true that heart suture has been proposed vaguely as a possible procedure and has been done on animals, but I cannot find that it has ever been attempted in practice." Today, only 60 years after these widely accepted prophecies were stated, surgeons throughout the world daily are planning and executing deliberately every

conceivable type of surgical manipulation of the heart.

In spite of opposition a number of surgeons performed experiments on animals and made observations. They transferred scientific facts and principles to the treatment of patients. This

always has been the way in which advances have been made in our medical knowledge and in our methods of treatment.

In 1882, Block successfully sutured

cardiac wounds in rabbits and advocated similar treatment for lacerations of the human heart. It early was recognized that rapid death often occurred as a result of acute cardiac compression following stab wounds of the heart.

PATIENTS ARE "WIRED FOR SOUND" IN THIS NEW HEART SURGERY

GEORGE S. HOLDERNESS

THE patient's heart will be able to withhold few secrets in the new cardiac surgery of St. Francis Hospital and Sanatorium at Roslyn, N.Y. This recently completed addition to a well known Long Island institution for child cardiac patients is designed with two objectives—the betterment of the immediate patients and the dissemination of knowledge on the subject to the medical profession. Toward this end the design has enlisted the aid of an elaborate audio-visual system

Mr. Holderness is an architect of the firm of Eggers and Higgins, architects, New York.

on which the sanatorium staff is counting to reveal much new information about the heart.

The cardiological significance of this new facility can be left to the doctors to describe in the medical journals. Suffice it to say here that through a combination of highly scientific instruments in the electronics field the patient's heart is literally wired for sound and revealed to general view—in a lecture room outside the surgery.

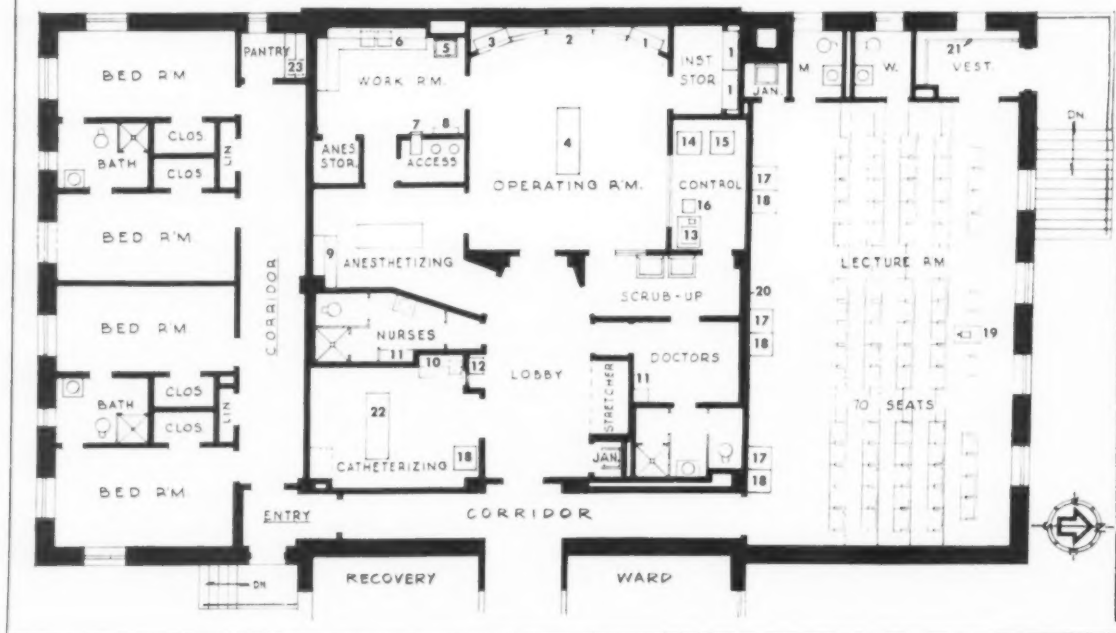
Through electrical leads built into the operating table, the patient is connected to a series of cardiographic recorders, each containing

three screens on which running oscillographs tell a continuous story of the heart's behavior during the operation. One screen shows electrocardiographic tracings, and another the intracardiac pressure. The third indicates (visually) the heart sounds and murmurs. A sort of speedometer shows the rate of beat, and a tape device makes permanent records for future reference and study. A smaller cardioscope stands on a pedestal near the operating table to guide the surgical team.

Every seat in the lecture room contains a receptacle for a stethophone, by means of which the oc-

PLAN LEGEND

- | | | |
|---|----------------------------------|--------------------------------------|
| 1. Instrument cabinet | 8. Water sterilizer | 17. TV receiver |
| 2. Angio-cardiogram illuminator, 3 tiers, each 17 feet long | 9. Counter and cabinets | 18. Oscilloscope |
| 3. Warming cabinet | 10. Counter, sink and cabinet | 19. Projector stand |
| 4. Operating table | 11. Lockers | 20. Chalkboard and projection screen |
| 5. Flushing rim sink | 12. X-ray control | 21. Coat rack |
| 6. Counter, sinks and cabinets | 13. TV monitor | 22. X-ray table |
| 7. Pressure sterilizer | 14. Oscilloscope master control | 23. Kitchen unit |
| | 15. Oscilloscope monitor | |
| | 16. Angio-cardiogram switchboard | |



A few surgeons were bold enough to attempt prompt operation with opening of the pericardium and direct suturing of the wound. Rehn of Frankfort was the first surgeon to suture successfully a lacerated heart. This occurred

in 1896 and represented an important milestone in heart surgery.

A number of experimental procedures were performed upon animals with varying results. These included operations upon the aortic valve by

Becker and myocardial resection by Elsberg, as well as numerous other physiologic studies by several different investigators.

A large number of surgeons contributed different technics that gave

DESIGNED FOR AUDIO VISUAL TEACHING AT CHILDREN'S HOSPITAL

cupant hears the sounds of the patient's heart and the remarks of the surgeon, *et al.*, over an intercommunicating system.

The operating light is a specially designed one of four units, containing in the center a color-television camera which carries the operation to viewing sets, also in the lecture room.

In another part of the new suite a preoperative catheterization of the patient's heart is performed. An angio-cardiographic x-ray film of the heart is made here, showing the patient's condition at fixed intervals as the x-ray-contrasting fluid circulates.

All of the various cardiac functions during this procedure are shown on the oscilloscopes in the lecture room and on a similar one in the catheterizing room.

Upon its completion the angio-cardiographic film, which may be as long as 50 feet, is placed in the operating room on a three-tier viewing box about 17 feet long, set into a curved wall to afford better view of the film from the operating area. By means of a panel board in the adjoining control room, the entire film, or any portions selected by the surgeon as the operation progresses, can be illuminated. Except during

the actual surgery, the television camera can be used to transmit an image of the illuminated film to the lecture room receivers.

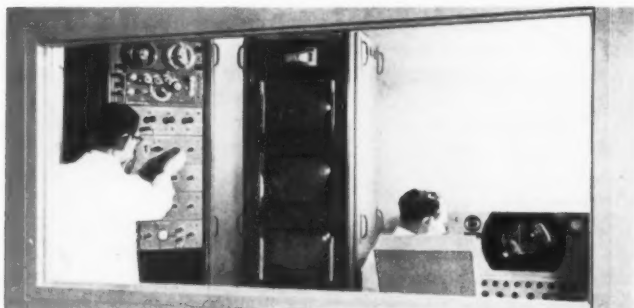
Also in the control room, under the supervision of medical personnel, are the monitors for the television and oscilloscope equipment. From this remote control the television camera can be focused and shifted as directed by the surgeon over the intercommunicating system.

Besides the actual surgical layout and lecture room, the project includes also a small suite of living quarters for resident doctors.



Left: Television camera is located in the operating lights, with three-tiered viewing box for angio-cardiographic film shown in background. Film is visible in lower two tiers only. Above: In lecture room, instructor points to screens on which running oscillographs show heart's behavior during operation.

Below: Looking from the operating room into the control room, showing television and cardioscope monitors. Right: This view of the control room pictures the television monitor and also the panel board for the angio-cardiographic film viewing box.



impetus to heart surgery. Carrel popularized the technic for vascular suturing which is used today. He predicted accurately the future development of vessel grafting, which in itself is an entire fascinating chapter in cardiovascular surgery. The work of Sauerbruch, Barthelemy, Dufour and Meltzer opened the door to safe intrathoracic operations. Prior to their investigations, the tremendous handicaps of open pneumothorax and mediastinal flutter rendered these procedures hazardous, if not impossible.

Between 1900 and 1920 a number of isolated cardiac operations were performed or attempted. These are of historic interest. In 1902, Sir Lauder Brunton proposed that the mitral valve could be opened with great benefit to the patient in cases of mitral stenosis. This proposal was supported by Arbuthnot Lane and Samways. In 1909 Bernheim produced experimental mitral stenosis by ligature circumclusion of the mitral ring. In 1908, Trendelenburg reported a series of attempts to remove pulmonary emboli by direct operation upon the pulmonary artery. However, it was not until 1924 that Kirschner recorded the first successful pulmonary embolectomy. In 1913, Tuffier successfully "dilated" the aortic valve of a human patient with aortic stenosis by finger invagination of the aortic wall! Doyen, in the same year, attempted to open a subvalvular pulmonic stenosis by passing a knife through the wall of the right ventricle. This effort resulted in a prompt fatality.

Between 1923 and 1928, Cutler, Beck and Levine, after extensive laboratory investigation, operated upon seven patients with mitral stenosis, using the technic of transventricular partial valvular excision. Most of these were unsuccessful and their work was discontinued. However, this was the first series of deliberate operative attempts to correct a structural deformity of the heart and served as a basis and stimulus for the many later investigations of this problem. In 1925, Souttar performed the first mitral commissurotomy using the atrial approach. This was essentially the same technic that is used today. Because the profession was not ready to accept fully this new type of therapy, 20 years passed before the problem was attacked again clinically. In the late 1920's, Rehn, Delorme and Churchill performed the earliest pericardiectomies for chronic cardiac compression.

The pioneering and continuing con-

tributions of Claude S. Beck have been fundamental and cover the entire field of heart surgery. During the early 1930's, he clarified the clinical syndromes of acute and chronic cardiac compression. His diagnostic triads and clinical observations in a large series of pericardiectomies are classic. He developed the technic of cardiac resuscitation by which many thousands of dead patients have been revived successfully during operations. Indeed, several patients who have died suddenly in parts of a hospital other than in an operating room have been restored to life. His investigations into the basic physiology and pathology of coronary artery disease are monumental. The Beck operation for coronary disease has found wide acceptance, owing to the excellent clinical results.

SURGICAL TREATMENT ACCEPTED

The correction of the simple congenital anomaly of patent ductus arteriosus fired the imagination of surgeons throughout the world and launched vigorous efforts in many centers to investigate all diseases of the heart and great vessels which might be amenable to surgical therapy. Strieder of Boston made the first attempt to ligate a patent ductus. His effort was unsuccessful. During the following year, 1938, Robert Gross, also of Boston, performed this operation uneventfully. He established another milestone in heart surgery when, along with Crafoord of Sweden, he resected a coarctate segment of the aorta in 1945. Today, surgical treatment of patent ductus and coarctation of the aorta is accepted and carried out when the diagnosis is made.

During World War II, Harken and others reported several series of brilliant successes in the treatment of wounds of the heart with retained foreign bodies.

In 1945, Blalock and Taussig introduced the subclavian-pulmonary artery shunt for the treatment of blue babies with tetralogy of Fallot. This gave additional impetus to the rapidly expanding field of cardiac surgery. During the following year, Potts reported on his work with aortico-pulmonary artery shunt. In 1948, Brock performed direct operations upon the pulmonary valve and infundibulum using a right transventricular approach.

In 1948, Harken of Boston, Bailey of Philadelphia, and Brock of London, all working independently, reported successful operations for mitral stenosis almost simultaneously. This single

event did more than anything else to place the heart and its abnormalities firmly within the realm of surgical correction. Their technic has been accepted by all and thousands of patients have benefited. Bailey's many other contributions include the development of technics for repair of interatrial septal defects; for correcting aortic stenosis and regurgitation, and for excision of ventricular aneurysms.

The most recent and dramatic episode in cardiovascular surgery has been the development of a safe, effective method for by-passing the heart and lungs in order to perform reparative procedures inside the heart itself. This has been an outstanding example of successfully applied surgical research and multi-specialty cooperation. Gibbon of Philadelphia did most of the basic work in perfecting the heart-lung apparatus. Recently, Lillehei and his group in Minnesota have reported large series of direct-vision intracardiac procedures using a simple bubble type of oxygenator.

Although many other surgeons have made important contributions to the development of heart surgery, space permits mention of only a handful of the most outstanding: DeBakey, Glover, Holman, Hufnagel, Shumacker and Swan. Each has done his share to elevate this specialty to its present high plane.

Modern cardiovascular surgery was born during the 1920's; it progressed sluggishly with a few outstanding exceptions during the 1930's; it gained momentum during the early 1940's, and burst upon the scene of medical progress with unbridled vigor in the late 1940's and 1950's. Although this was the last surgical specialty to evolve, its bases are solid and its roots permanent. Direct observation of cardiac abnormalities and operative correction of mechanical defects and physiologic alterations will continue to increase in importance. The modern surgical cardiologist has removed the barrier of the chest wall from the problem of treating the patient with heart disease. Like the automobile mechanic who lifts up the hood of a stalled car to check the motor, we now are able to examine directly the human "motor" in order to correct its abnormalities. Today, the medical cardiologist is especially keen to make an accurate diagnosis so that corrective surgical therapy may be instituted whenever possible.

It should be emphasized that the en-
(Continued on Page 144)

A Girl's Best Friend Is Her Hospital

And a hospital's best friend, from the standpoint of good public relations, is a baby like this one selected by MacNeal Memorial Hospital, Berwyn, Ill., to report to the community on the hospital's 25 years of service

Narrator of MacNeal Memorial's annual report is this baby whose likeness decorates several pages of the brochure, with accompanying captions, as shown here. Opposite the photographs in the report are facts and figures on the hospital's progress. The story starts in 1956 ("This is where I came in"), which marked completion of a \$3½ million expansion program as well as the silver anniversary of the administrator, Francis J. McCarthy.

"This is where I came in"



"Did you say 3½ million?"



"And with 25 years' experience"



"You mean I'm not the only one?"



"If the public demands it"



"I've got the figures to prove it . . ."



"Bills, bills—nothing but bills"



Above, left: She wasn't the only baby to arrive at MacNeal Memorial in 1956; there were 2615 of them, in fact. Right: And besides babies, the hospital cared for 12,634 patients that year.

Above, left: The figures show that both the laboratory and the radiology department did a record breaking business: an increase of 17 per cent over the previous year. Right: But all this service costs money. Somebody has to pay those bills.

"Let's have a little applause"



"As chairman of the milk fund"



"You think this is the end—why it's just the beginning"



Far left: Give the hospital a hand for the job it has done in caring for so many people. Center: The milk fund is important to a baby. So, how about a small contribution. Left: It's the end of the annual report—but only the beginning of the hospital's plans for the future.

"The Way We've Always Done It" Isn't the Way to Solve the Problem of Staffing the Floors

A MODERN HOSPITAL ROUND TABLE

Dr. Kallejian: Staffing is a problem that extends throughout the entire hospital. Every department is concerned with making the maximum use of every individual and group of individuals. That part of the problem which concerns us especially is: How can we best utilize an individual nurse or group of nurses?

This has been a problem of hospitals for many years; in the past, we have tended to compromise in favor of some of the traditional practices in hospital construction, hospital organization, and administrative procedures. In order to solve staffing problems now we must look critically at some things which we have always accepted as fixed and unalterable.

First of all, we must make an evaluation of the needs of patients, not only needs *per se*, but needs that are dynamically related to each other. We must decide what needs the hospital will attempt to meet and those which it will attempt not to meet, and determine which are long-term and which are short-term needs.

A second step is critical evaluation of nursing functions, including the physician and his function, what nurses do, and their relation to the physician.

Third, we must analyze the selection, placement and training of nursing personnel and subprofessional personnel in the nursing service.

Fourth, we need to study the physical plant and the formal structure of hospital organization.

The fifth category for study is the quality and character of supervision.

Finally, we must analyze the on-going system of evaluation—that is, the procedure by which we evaluate what

The biggest, toughest problem hospital administrators face today is how to staff the nursing floors: where to find the necessary nurses, what to use in place of the vanishing R.N.'s, and how to make the best use of the few who are left. Because this problem is of such concern to hospital people everywhere, The MODERN HOSPITAL arranged to record a panel session on "New Ideas for Old Staffing Problems," held in connection with the National League for Nursing meeting last May, at which many useful ideas and suggestions were put forth by panelists and audience. With some editing to eliminate repetition and irrelevancies, the recording of the session is presented here. Raymond P. Sloan, chairman of the board of directors of The Modern Hospital Publishing Company, served as moderator. Members of the panel were: Verne Kallejian, chief, Educational Activities, American Hospital Association; Deborah Pratt, R.N., supervisor of nursing and surgical specialties, Hartford Hospital, Hartford, Conn.; Gordon A. Friesen, hospital consultant, Washington, D.C.; Herluf V. Olsen Jr., assistant director, Rhode Island Hospital, Providence; Ruth Sleeper, R.N., director, School of Nursing and Nursing Service, Massachusetts General Hospital, Boston; Lt. Col. Elizabeth L. Breitung, R.N., nursing methods analyst, Army Nurse Corps, Washington, D.C., and Jessie Scott, R.N., nurse consultant, U.S. Public Health Service, Division of Nursing Resources, Washington, D.C.



Raymond P. Sloan

we are presently doing in terms of its effectiveness in meeting goals.

Mr. Sloan: Now we will try to keep all these points in mind as we discuss some of the specific programs that have been established to help meet staffing problems. For example, Miss Pratt, will you give us your ideas on the reassignment of patients in the minimal care unit?

Miss Pratt: I would like to tell first how we happened to develop minimal care units, and what we find they have done for us at Hartford Hospital. The

development of the minimal care units came about because of several acutely felt needs. We have three units in operation now; two are minimal care units for short-term, nonacutely ill patients, and the third is a convalescent unit to which we move patients who are in the convalescent stage of their illness after surgery. They all are meeting our needs so far and helping us a great deal.

One of these needs was the great urgency in the community for us to provide more hospital admissions.

HOSPITAL AND NURSING LEADERS OFFER NEW WAYS TO MEET STAFFING PROBLEMS



Kallejian

Pratt

Friesen

Olsen

Sleeper

Breitwig

Scott

There was a long waiting list which was a source of much concern to patients—and prospective patients—to the doctors, and to the hospital.

We had hospital units that were available for use, but not enough staff to cover those units, especially professional staff. We needed to spread nursing services despite the shortage of professional nurses, and we were searching for ways to give better care to patients.

To meet these needs, there were two methods we could use: Patients who did not require the attention of a professional nurse for the full 24 hours but could be cared for part of the time (chiefly from 7 p.m. to 7 a.m.) by a licensed practical nurse might be placed in one area. These were patients coming in for diagnostic procedures, interval appendectomies and herniotomies, D and C's and hemorrhoidectomies.

We also felt that better care could be given to acutely ill surgical patients by concentrating more professional help on three of our general surgical units. Then as patients recovered from their surgery and reached the convalescent period they could be transferred to a unit which was staffed the same as the minimal care unit.

All planning has been based on the concept of organizing the admission and care of patients according to the degree of illness rather than by the clinical nature of the disease. We feel that greater utilization has been made of the skills of both the professional nurse and the licensed practical nurse, and that better care is being given to patients, both the acutely ill and the nonacutely ill.

Mr. Friesen: I think we have to change our whole philosophy. There is a tendency for us at the present time to take a group of elements and put them together like a jigsaw puzzle. Build the building, and then adjust the organization to suit the building.

Instead of that, what we ought to do is develop our organization first, and then put a roof over it. We say we're thinking of the patient, but what happens? The doctor orders a sedative for the patient at 10 o'clock; we wake the patient up at 5:30 in the morning; we give the patient dinner at 11 o'clock, light lunch at 4 or 4:30, and if we're very generous, a cup of hot chocolate at night. But remember—we're thinking of the patient!

Let's change our philosophy. Let's put everything on the production line that the nurse and the doctor need to give the patient complete care.

Mr. Olsen: We feel that the administration has the obligation to provide the atmosphere for change and development. Included in that are such things as setting up patient care meetings on the various specialties, and establishing par systems in sterile and nonsterile supplies, and in linens, so that the nurse doesn't have to worry about requisitioning supplies. That's all done for her, and we find that it saves us a considerable amount of linen.

We also have interdepartmental conferences—meetings of all the various departments—and iron out many of our problems.

In connection with these we have been striving for years to get the nursing department to release certain non-nursing functions to other departments—housekeeping, dietary, the thing you've all heard before. We've done that to a great extent. But administration has been guilty of overlooking the fact that we hold nursing accountable in the final analysis for what happens on the nursing unit, whether it is a dietary problem or a housekeeping problem. They are all patient care problems, and we hold nursing accountable, whether we should or not.

Recently, we've been developing the idea that the supervisor should be the coordinator of patient care. As coordi-

nator, we would expect her to be responsible for four nursing units. We would expect her to initiate meetings of the various service groups, such as dietary and housekeeping, and to assume a rôle of leadership. Since we have started this, we have been amazed by the degree of interest shown by several of our supervisors, and the amount of progress we've made with the medical staff and in certain problem areas like central supply and housekeeping, where we had "little empires."

Mr. Sloan: Miss Sleeper, what is your opinion of the maximum care unit as a way to save the nurse's time?

Miss Sleeper: We've had maximum care units longer than I can remember on both surgical and medical wards. My concern today as we talk in general terms about maximum care units is this: What's maximum? For whom? Is it a unit to provide maximum nursing? Or is it a maximum care unit in terms of all the care which the patient needs during the 24 hours of each day? If we are contemplating setting up a maximum care unit or considering what we have now in order to make it more effective, the first thing we ought to decide is: "What is our purpose in operating such a unit?" This is a problem to be discussed by nursing, hospital administration, medicine and all the service groups within the institution.

Maximum medical care means that a doctor must be on the ward or readily available for 24 hours, in addition to maximum nursing, maximum laboratory, maximum supplies, maximum lifesaving equipment, and maximum service from all units in the hospital. You can't have maximum care from just one group and reach your goal.

I think the geography of a maximum care unit has a great deal to do with its success. If the nurses or others have to walk so far that it takes them away from their patients, you

"If you have 100 nurses, you really have 70 nurses and 30 housekeepers"

create an emergency situation. The maximum care unit also is a tremendous problem for inservice education. The nursing staff there—all of them—must know how to use the lifesaving devices and know the difference between maximum care and the minimum type of care.

The unit is not finished when it is established. There must be constant reevaluation of its purpose, and what is being achieved. Otherwise it might be better for us to leave the patients where they are now. Only frequent evaluation, with frequent reconsideration of our methods, our selection of workers, our training of workers, and our use of supplies, will make this unit truly maximum in its care for patients.

DETERMINE STAFFING STANDARDS

Lt. Col. Breitung: The need for more accurate determination of staffing standards for inpatient care has long been recognized. In the past few years intensive research studies have been conducted in nursing services, involving the differentiation of functions, the reallocation of duties according to levels of skill, and the measurement of service provided to different types of patients by various members of nursing teams.

Research indicated that it was essential to relate staffing to the acuity of illness of patients and the services to be performed as indicated by the doctor's orders.

For this reason the Army Nurse Corps worked out a method of classifying patients according to their nursing needs. It is called patient categorization. This system is based on analyzing the individual patient's nursing care needs. You may have an acutely ill patient who makes little demand on the nursing service. On the other hand, you may have an ambulatory, convalescent patient who makes great demands on the nursing service. The factors which determine how a patient will be categorized are: (1) the nursing procedural requirement, (2) the patient's physical restrictions, (3) emotional factors, and (4) instructional and observational needs.

The elements which influence categorization are inherent in the work initiated by the doctor, the head nurse, and the patient himself and will vary in complexity with every patient. We are using four categories:

Category 1 is a patient who requires intensive nursing care and is helpless.

Category 2 is a patient who requires moderate nursing care, and some assistance.

Category 3 is a patient who requires minimal nursing care and is ward ambulatory.

Category 4 is a patient who requires supportive care on a clinic basis and is convalescent.

Our category 4, though it is similar to the minimal care unit, is not quite the same thing. In a civilian hospital you probably would not have what we call a category 4 patient. Any patient reaching category 4 in your hospital would be discharged to home care. In the military we cannot do this. We have soldier patients.

The analysis of patient needs is used in daily assignments of available nursing personnel, so as to divert nursing care to patients who need it most, and thereby provide better nursing care. Periodic summaries of the entire hospital can be done to provide a more equitable distribution of personnel. Thus a collection of one year's category data would provide a fairly accurate picture of the year's work load and could be a basis for estimating the next year's requirements.

Miss Scott: We have several utilization studies under way in hospitals throughout the country. These studies are being set up to find out how much time the nursing staffs are spending on nursing activities. The whole purpose of the studies is—more time for nursing.

An examination of the data we have compiled from 34 hospitals reveals an interesting and disturbing picture. If we look at these data in terms of time spent on nursing by category of personnel, we find that:

1. The head nurse has 59 per cent of her time to spend as a head nurse.

2. The professional staff nurse spends 76 per cent of her time as a professional staff nurse.

3. The practical nurse spends 75 per cent of her time as a practical nurse.

4. The nurse's aide spends 68 per cent of her time as an aide.

Thus we have a head nurse who is the key person on the nursing unit—she's in a leadership position—but she has the least amount of time of anyone else on the nursing staff to spend on her own particular job!

If we look at it in a different way, the hospital is purchasing 100 per cent of head nurse service but netting only 50 or 60 per cent.

In round numbers, we find that nursing staffs are spending about 70 per cent of their time on nursing and 30 per cent on nonnursing duties. If you have 100 nurses on your staff, you really have about 70 nurses and 30 housekeepers, dietary maids, and people who count things. If we look at these data in terms of hours of care these hospitals are providing for patients, an eight hour shift is 1.4 hours of actual care.

WHO IS OBSERVING THE PATIENT?

Who is with the patient? Who is looking at him? Who is observing him? Who is determining his need for care? We find that the head nurse spends 22 per cent of her time with the patient, the R.N. 38 per cent, and the nonprofessional staff 48 per cent.

In terms of direct care to patients, the R.N. spends 29 per cent of her time in direct patient care at the bedside, but it takes 37 per cent of her time to get ready to do this, whereas the nonprofessional staff members spend 32 per cent of their time at the bedside, but it only takes them 22 per cent of their time to get ready to do it. So I would like to know, what's keeping our nurses in the utility rooms? A lot of this is job assignment that keeps the R.N. spending more time in indirect care for patient-centered activities, rather than in direct care.

This brings up other questions. What about supervision? The head nurse spends one or two hours a week on staff service supervision and inservice education and supervision. But we have to remember that this is one

"The head nurse has the least time to spend on her own particular job"

or two hours out of part of her week, not out of 40 hours, because she doesn't have 40 hours to spend as a head nurse.

Mr. Sloan: Miss Sleeper was late in getting to this meeting, because she had to open up 40 beds overnight. How did you open up 40 beds overnight, Miss Sleeper?

Miss Sleeper: When my assistant and I were ready to leave at 3 o'clock on Thursday we were called into an administrative meeting which consisted of the general director and assistant director of the hospital, and they told us that we were facing an overwhelming budget, that every department was to be asked to cut down, and that the way nursing could assist, instead of cutting down, was to open more beds. On Friday we had a meeting with the assistant director of nursing and planned how we would approach the situation. I then asked the nurses for advice as to how we might get the ward opened. I have something like seven or eight pages of suggestions as to what we could do to save time in nursing, almost all of which are valuable and many of which are new.

LETTER SENT TO RESIDENT STAFF

Then on Monday the general director and other members of the hospital administration and I met with the resident medical staff and the chiefs of staff to talk with them, and a letter went out to the resident staff carrying the suggestions of the nurses from the wards. Before I came away at 3 o'clock on Tuesday, housekeeping had cleaned the ward, pharmacy had re-furnished the medicine closet in the utility room, maintenance had moved off old equipment and moved on the proper equipment, dietary had prepared itself, the laboratories were alerted, and the assistant director of nursing had a time sheet almost filled in with head nurses' offerings of "I'll give you this" and "I'll give you that," so that we had a head nurse, an assistant head nurse, and sufficient staff to start us off at 7 o'clock this morning.

Now the reason I think this is important is not just that we opened the beds that the hospital wanted us

to, but that the nursing department said, "We can't do this alone. We can do this only if the medical staff will work with us." We needed help. We needed communication with the medical staff. This isn't just an emergency now; this is going to go on. We've all got to find some way to communicate with each other so that we understand each other's problems. Each group in the hospital arranges its schedules so that the patient's needs can best be met.

Mr. Sloan: Will you tell us a little more about what the doctors were willing to forego?

Miss Sleeper: I can tell you what we asked them to forego. I haven't had their response as yet, but I'm sure we'll have cooperation. We asked that all orders, except emergency orders, be written by 6 o'clock at night; all physicals and tests except emergency ones be done by 6. Today they're being finished at 11 and 12 o'clock in the evening.

We asked that patients be discharged earlier so there would be time to get the new admissions ready and into their beds for their physicals and their care in the afternoon.

We asked them to review their orders with the head nurses to see what they could eliminate and still keep the orders at a safe point for the patient, but not to try every test that is known or available at the hospital. This included cutting down a great many blood pressures. We asked that, where it could be done, medicines be combined into one dose instead of three. For instance, it doesn't make any difference whether you get a complete swatch of vitamins at 10 o'clock in the morning or some at 10, 2 and 6 o'clock. But it makes an awful lot of difference to the nurse! It was that type of thing.

Mr. Sloan: Mr. Olsen, you mentioned the ordering of linen being done by someone other than nursing. Do you mean new linens, or the daily linen supplies for wards?

Mr. Olsen: Daily linen supplies for the wards. We have a linen committee that includes a supervisor of nurses, a head nurse, and a staff nurse. With an administrative assistant, the com-

mittee established what they thought their daily needs would be on each of the units, recognizing the difference between the various specialties. Once these plans were established they were reviewed with weekly meetings of the linen committee to be sure they were working properly. The committee now meets only once a month; they discuss common problems, and there is an extreme amount of interest in the amount of linen being saved. We are told that nursing is completely confident that when they go to their linen room they'll find the linen they need to take care of the unit that day. There's no hoarding of linen at all.

Miss Sleeper: Could Mr. Olsen say a word about the way all the supplies at his hospital are replenished?

SUPPLIES REPLENISHED DAILY

Mr. Olsen: The linen replacement is done by a member of the laundry department, who goes around and does this daily, before the linens are drawn upon. The same thing is true with other supplies. A supply committee set up much like the linen committee has accomplished the same result with other supplies, and our students say that when they get transferred to a different unit they find the supplies just where they were on the previous unit.

Our stores department goes around every night, checking the par, determining what's in the drawers or the utility rooms, and bringing it up to par.

Lt. Col. Breitung: We have completed one study on a general medical ward which has given us the number of hours of nursing care that were required by those patients. I will give them to you for what they're worth:

A category 1 patient required 2.7 hours of professional nursing care, 2.39 hours of medical technician care, and 1.12 hours of medical corpsmen and ward clerk—a total of 6.21 hours.

A category 2 patient required 1.01 hours of professional care, 1.06 hours of medical technician care, 0.61 hours of medical corpsmen and ward clerk, or a total of 2.68 hours.

A category 3 patient required: 0.54 hours of professional care, 0.55 hours

of medical technician care, 0.38 hours of medical corpsmen and ward clerk—a total of 1.47 hours.

A category 4 patient required 0.39 professional nursing supervision care hours, 0.52 hours of medical technician, and 0.37 hours of medical corpsmen and ward clerk, or a total of 1.28 hours.

These hours will apply only to general medical patients. We are doing a similar study on a general surgery ward, but as yet have no results.

Nurse: I wonder how we can help to—I don't want to say educate—but help the doctors to help us. With the nursing shortage so acute and medical strides continuing at such a tremendously fast pace, they are bound to help us face the situation if patients are to get proper care.

DOCTOR MUST LEARN, TOO

In our particular situation, we have difficulty with the residents. These boys are often tied up in the operating room from early morning until late in the afternoon, so the heaviest order writing, the studies for the next day, occurs on the 3 to 11 shift. I have had nurses coming on as early as 6:15 a.m. in order to get studies started. This does not give job satisfaction to the nurse, and it's hard, too, to make the young nurse realize that this young doctor also has to learn. How are we going to get together during this acute period?

Miss Sleeper: I think in our situation we have not done enough to plan together with the resident staff, so that that planning became part of their education. Only as we can get the assistant directors of nursing and the head nurses and supervisors to sit down with their particular doctors, on their individual floors, to interpret the situation is it ever going to be clear. Our men say to us: "What's the matter that you can't get nurses? Why don't you pay them enough?" In other words, they've no concept of the actual situation. I think that's partly our fault for not having found some way to get the two groups to sit down together.

Nurse: We also have a committee on patient care functioning with top-level personnel. The doctors on that committee are our top chiefs. I am wondering if the residents shouldn't be invited to sit on that committee, and perhaps some supervisors.

Mr. Olsen: We tried the over-all patient care committee idea in the be-

ginning, and it was a complete flop. There was no interest. The chiefs would come and they talked at a high level, about big concepts, and it became a gripe session.

So in occupying our new building we saw an opportunity to sit down with the services involved in each unit: with the head nurses and supervisors who are involved; with the residents and interns who are assigned; with the administration, and then as need be with the dietary department and housekeeping.

We've talked about problems on a specific unit. We've solved problems.

PRIVATE DUTY AT A MINIMUM

Nurse: I'd like to know if the maximum care unit in any way affects the assignment of private duty nurses.

Miss Sleeper: We don't feel the need for them there. If private duty nurses are requested for this unit they are on exactly the same basis as private duty nurses in any other part of the hospital. But the maximum care units that we have now and have had in the past have been for ward patients. Therefore private duty nursing is at a minimum.

Sister: Has anyone used floor managers—lay floor managers? Are they men, or are they women? And are you happy with them?

Voice: We have a person at the Rhode Island Hospital that fits this description, but we call her an administrative secretary. The reason we instituted this position was that we felt we just couldn't put any more people in back of the desk. We had a vacancy for an assistant head nurse, and we found that 75 per cent of her work was clerical work. This person works out very well. She transcribes orders, writes medicine cards, makes phone calls to the lab to put blood on call, and takes care of stat orders. We find that she's very valuable.

Mrs. Wolfe: For several years we tried out a floor manager plan at Memorial Hospital, New York City. The managers were trained in and came directly from hospital administration. They were specially selected people, and of course the salary was higher than the type of ward clerk one is used to. We set up various types of guides for them to use, and helped them in working with the nurse administrator—that would be the head nurse on the ward or the unit—and for some reason there was always some friction. It was also expensive, and

we have since discontinued this. We did it for about two and a half years on two units.

Voice: Some of us, and perhaps all of us, are experiencing difficulty in motivating nurses to meet the needs of patients in relation to the hours when they will work. If there is an effort at cooperation, how much is nursing giving way? How are we adjusting the morning to meet the requirements of the evening?

Miss Sleeper: In our situation, when we asked that the orders be reduced in the evening period, we had two thoughts in mind: One was to reduce the number of people that we had on the evening shift, because it's a very difficult period to supply personnel. But we were also thinking of the fact that since 1939 we have doubled our evening staff, and perhaps we have tripled it, because of this system whereby the interns' and residents' work was organized in such a way that they couldn't get to their wards until evenings.

Now we're saying, "Does every surgical resident and intern have to be in the operating room?" Or can you have one who stays on the wards to get things done in the daytime? Because we cannot go on indefinitely adding to the evening staff; soon it's going to be as large as the day staff is.

We're also trying to see the side of the doctors. They can't change their schedules completely overnight, either. It must be something that we work out together.

Voice: We're all intrigued with the idea of minimal care units. We know how they meet the hospital's need for better utilization of nurse personnel, and the community's needs for providing hospital beds. But I'm a little curious as to how it will meet the patient's needs for learning at the time when he is best able to learn. We are turning him over at a period when he is most ready to learn, before he goes home; when he needs teaching, yet the people working with him will be the least skilled of our workers.

Miss Pratt: We do have professional nurses on the minimal care unit during the period when most of the teaching would be done, so I feel the staff is as adequate to teach on the minimal care unit as it would be on any other unit.

As far as the reaction of the patient is concerned, it's very interesting. Some patients have been admitted to a

(Continued on Page 102)

What It Costs to Use Needles and Syringes

Survey of the use and reuse of hypodermic needles and syringes in seven general hospitals suggests ways in which the costs of processing and use can be reduced

A COST analysis* that concerned itself with the procedure followed and the continuing costs entailed in preparing hypodermic needles and syringes for use and reuse has revealed four important requirements that should be present to achieve low costs in the processing of reusable needles and syringes. These are:

1. Centralize in one area as much of the processing as possible.
2. Package needles and syringes in containers that can be used without loss.
3. Set up a separate work area for all processing and mechanize where possible.
4. Control the movement of needles and syringes under a formalized procedure.

The cost analysis of the use and reuse of hypodermic needles and syringes in the seven general hospitals studied has produced results that can be used as guideposts for other general hospitals. Processing labor was generally the biggest single cost element. Syringe cost, either through breakage or pilferage, was the next most costly element, while needle cost and raw material costs followed. Although the results can be used as a guide, they cannot be considered a statistical sample for all general hospitals.

The objective of the cost analysis was to discover all of the direct costs concerned with using and processing hypodermic needles and syringes. These direct costs were further segregated as to hypodermic and intramuscular size

needles and as to the three most widely used syringe sizes, namely 2 cc., 5 cc. and 10 cc.

Each of the seven general hospitals in this study was located in a different city in the United States. Two of the hospitals were in the East, three in the Midwest, and two in the West.

Two of the seven were supported by religious groups and the remaining five were nonsectarian and publicly supported. The hospitals ranged in bed capacity from 160 to 701 with an average of 426. Patient days totaled 893,330 and averaged 127,620.

All costs presented in this report have been classified in the order of the hospital bed capacity. Hospital A is the smallest and Hospital G is the largest.

All the survey work was carried on with the consent of the hospital administrators. Storeroom, purchasing, central supply, nursing floor, and accounting records were made available to the survey group. The information on the records was used as presented and no attempt was made to check or audit the accuracy of the records. The cost surveys required approximately two weeks in each hospital.

METHODS USED TO PROCESS

All seven hospitals had different procedures for cleaning and sterilizing needles and syringes. However, they could be classified into two broad categories as to method as follows:

1. Central supply processed the majority of all needles and syringes. Under this procedure needles and syringes were gathered periodically from the areas serviced and taken to central

supply. Needles were placed in a cleaning solution and either boiled or placed in an autoclave for presterilizing. The barrels and plungers of the syringes were separated and washed by hand or left to soak in a soap solution. The next operation was to rewash needles and syringes. This was done with a machine in most of the hospitals. After the final wash, the syringes and needles were inspected and packaged in either paper, cloth, glass or metal containers. The final step was to autoclave and to store for future delivery.

2. Both nursing floors and central supply processed needles and syringes. Under this category, the central supply procedure was the same as described under No. 1. On the nursing floors, used needles and syringes were laid in a cleaning solution. Periodically these needles and syringes were washed by hand at the nursing station. They were then inspected and packaged in containers with gauze pads used for padding between syringes and as a holder for extra needles when required. These containers were then autoclaved and returned to the nursing station for the next series of uses.

Five of the hospitals could be classified into the first category. These were Hospitals A, B, C, E and F. The remaining two, Hospitals D and G, were either planning to change to a complete central supply operation when space permitted or were in the process of making such a change gradually.

COST SUMMARY

The total direct cost per injection of processing and reprocessing hypodermic needles and syringes was (Continued on Page 79)

*This cost analysis was made in seven general hospitals by Arthur Young & Company, accountants.

PROCESSING TECHNIQUES FOLLOWED IN SEVEN HOSPITALS

HE central supply procedure in six of the seven hospitals required that all needles were to be presterilized immediately after return from the nursing floor and before the actual cleaning process took place. The heads of central supply all felt that this was necessary in order to reduce the possibility of infection to the aides handling the needles. This presterilizing procedure, prior to actual cleaning of needles, was not followed where the nursing floors processed their own needles. Nor was this followed in most of the laboratories or operating room needle cleaning.

In all but one hospital, needle cleaning machines and syringe washing machines were used. Five of the seven hospitals had and used needle sharpeners. One hospital had a sharpener but could not find an employee skilled enough to use it. Another threw out needles when they became dull. Six of the seven hospitals used syringes with interchangeable barrels and plungers except for some of the largest sizes.

Hospital A

Central supply processed all needles and syringes, including those used for nursing floors, laboratory, operating room and clinic. Sterile files were used for packaging the majority of 2 cc. and 5 cc. syringes which have 1 inch needles attached. Hypodermic size needles, 24 x $\frac{3}{8}$ inch, were placed in a tray on a gauze strip. All other needles were packed in capped glass constrictor tubes. Other sizes of syringes were wrapped in a piece of gauze and packed in paper envelopes for sterilization. Central supply was open on a long shift basis (7 a.m. to 5:30 p.m.) seven days a week.

Hospital B

Central supply processed all needles and syringes used on the nursing floors. The laboratory and operating rooms each processed their own hypodermic equipment. In central supply, which was open 24 hours, seven days a week, all syringes were packaged in paper envelopes and sterilized. Needles were placed in glass constriction

tubes with cotton and paper caps and sterilized. The laboratory followed the same practices as central supply. In the operating room area, the needle, in constrictor tube, and syringe were both placed in the paper envelope and sterilized.

Hospital C

Central supply was open seven days a week, 24 hours a day. It served all the nursing floors and laboratory while the operating room processed its own needles and syringes. Syringes with needles attached were laid in large metal pans, surrounded by abdominal pack material. The pan was then covered with a cotton cloth, tied tight with cord, and sterilized. A typical nursing floor pan included twenty 2 cc. syringes with 20 x $1\frac{1}{2}$ inch needles, fifteen 2 cc. syringes with 25 x $\frac{3}{8}$ inch needles, and five 5 cc. syringes with 22 x $1\frac{1}{2}$ inch needles. Additional syringes were packaged in a cloth wrapper and tied. Extra needles were placed in a cardboard needle guard and into a glassine envelope.

Hospital D

Central supply primarily processed needles and syringes for the laboratory work. However, some of both were used for other purposes on the nursing floor. In central supply syringes were wrapped in paper wrappers and taped closed. Needles were packaged in glassine envelopes. Central supply was open on the morning shift only, six days a week.

Each nursing floor, clinic and the operating room processed the needles and syringes used for most medications. Stainless steel pans were used, with syringes laid at one end, each layer separated by gauze pads, and needles threaded through gauze pads laid at the other. These pans were then sterilized on each nursing floor.

Hospital E

Central supply processed all needles, except those used by the laboratory, and all syringes, except those used by the laboratory, operating room and maternity department. In central supply approximately 40 per cent of the syringes were packaged in envelopes. The

remaining syringes were placed in covered pans. About half of the needles were packaged in glassine envelopes. The remaining needles were threaded through gauze pads in units of five and placed in covered pans with syringes. Central supply was open 24 hours, seven days a week. The laboratory packaged syringes by wrapping five in a cloth and sterilizing them. Needles processed in the laboratory were placed in glass constrictor tubes. Maternity used envelopes for syringes but wrapped each syringe in a gauze pad before placing it in the envelopes.

Hospital F

Central supply processed needles and syringes for use on the nursing floors. Other service departments, including laboratory, operating room, clinic, pharmacy and emergency, followed their own sterilizing procedures. In central supply sterile tubes were used. The sterile tubes contained a 2 cc. syringe with 25 x $\frac{3}{8}$ inch or 22 x $1\frac{1}{2}$ inch needle attached. All other needles were packaged in glass constrictor tubes. All other syringes were wrapped in a cloth wrapper and sterilized. Central supply was open 24 hours, seven days a week. The laboratory used cloth wrappers for syringes and constriction tubes for needles.

Hospital G

At the time of the survey central supply was just beginning to take over all syringe and needle processing from the various nursing sections. As a result, certain nursing sections were serviced with both needles and syringes by central supply, other sections were serviced just with needles, and a third group of sections processed their own hypodermic instruments. In those nursing sections that processed their own syringes and needles, sterile files were used for 2 cc. and 5 cc. syringes with 22 and 24 gauge needles attached. Flat pans were used for other sizes of syringes. All needles except those attached to syringes in sterile files were processed in central supply.

TABLE 1—INJECTION BY TYPE OF SYRINGE

INJECTION COUNT	HOSPITALS							Total
	A	B	C	D	E	F	G	
1 cc. Tuberculin and Insulin.....	2,074	9,235	29,828	5,458	13,312	19,461		
2 cc.....	39,672	131,645	177,559	34,987	317,564	186,937		
5 cc.....	9,240	39,915	22,001	53,196	68,952	21,143		
10 cc.....	5,748	64,210	31,010	52,180	53,612	19,208	Not Available	
All Other Sizes.....	23,064	20,000	46,195	56,427	55,848	3,602		
Total Injections.....	79,798	265,005	306,593	202,248	509,288	250,351	329,820	1,943,103
Patient Days for Year 1956.....	55,593	100,935	133,064	124,168	111,696	177,390	190,484	893,330
Injection per Patient Day.....	1.435	2.626	2.304	1.629	4.560	1.411	1.732	2.175

TABLE 2—TOTAL COST PER INJECTION

INJECTION COST—TOTAL	HOSPITALS							Average
	A	B	C	D	E	F	G	
Raw Materials.....	\$.0023	\$.0095	\$.0012	\$.0093	\$.0090	\$.0019	\$.0111	\$.0063
Needles.....	.0089	.0046	.0085	.0134	.0029	.0080	.0039	.0072
Syringes.....	.0225	.0229	.0309	.0599	.0108	.0183	.0453	.0300
Processing Labor.....	.0124	.0560	.0335	.0446	.0339	.0260	.0428	.0356
Total Cost per Injection.....	\$.0461	\$.0930	\$.0741	\$.1272	\$.0566	\$.0542	\$.1031	\$.0791

Note: Overhead cost has not been included in any of the above costs. It was not possible to develop comparable overhead in all seven hospitals. In the several hospitals where overhead costs such as supervision, utilities, floor space, maintenance and supplies were allocated to the central supply department the per injection cost ranged from \$.0069 to \$.0182 per injection.

mic needles and syringes in the seven hospitals is as follows:

Hospital	Total Cost per Injection
A	\$.0461
B	.0930
C	.0741
D	.1272
E	.0566
F	.0542
G	.1031

These costs exclude overhead. In the sections that follow the various elements of these direct costs are analyzed in detail.

ANALYSIS OF ELEMENTS OF COST

The costs collected in the surveys of the seven hospitals have been classified into four elements as follows: (1) raw material, (2) needles, (3) syringes and (4) labor.

Each of these elements is explained in detail in the paragraphs that follow.

1. Raw Material. Raw materials included those purchased items that were expendable after a single use. They included such items as syringe envelopes, needle envelopes, washing materials, gauze pads, labels, staples, sterilization indicators, alcohol and ether. Unit purchase prices for this material were obtained from the hospital purchasing agents, and usage from the storeroom and purchasing

records. Usage of these materials was based on the historical records for the year 1956. On paper goods a loss factor of 2 per cent was allowed, and in cotton goods a loss of 1 per cent was allowed.

2. Needles. In order to obtain a representative sample of the number of needles used, the usage over the last six months of 1956 or the entire year 1956 was determined from storeroom delivery records or purchasing records for the period. Usage and costs were collected for each size needle used. The unit purchase price for the needles was elicited from the hospital purchasing agents.

3. Syringes. Syringe usage was determined in the same manner as that of needles. Each size of syringe was kept separate. In developing the costs for needles and syringes it appeared reasonable to assume that there was no change in the working inventories of these products in the hospital.

4. Labor. Processing labor cost, as presented in Table 2, is a summarization of the labor operations performed during the process of sterilizing and packaging needles and syringes. These costs were developed by time studies made while observing representative quantities of material processed or by obtaining estimates of labor hours required for processing from the super-

visors of the various departments. In all cases where time studies were used, no attempt was made to rate the employee or employees in terms of a "normal" day's work. The time collected was extended by the labor rate and divided by the quantity of material processed to obtain the unit cost.

In order to develop labor costs separately for needles and syringes certain labor cost allocations were made of the joint costs that applied to both. At all the hospitals these joint costs were less than 15 per cent of the total labor cost. The allocation of the joint costs was made by dividing these costs equally between needles and syringes.

As shown in Table 2, Hospital A has the lowest labor cost on a per injection basis. This is due almost entirely to the fact that most needles and syringes processed are not packaged in paper or gauze. This same fact holds true in Hospital F, which is next lowest in labor costs. It is apparent that the method of processing and packaging has a substantial effect on the ultimate labor cost.

In those hospitals that processed needles and syringes in more than one department, the labor costs in those departments were weighed on the basis of injections given from the needles processed in each department. For example, if the needles and syringes that

TABLE 3—NEEDLE COSTS—HYPODERMIC AND INTRAMUSCULAR—PER INJECTION

INJECTION COST—NEEDLE ONLY Type of Needle	HOSPITALS						Average
	A	B	C	D	E	F	
Hypodermic							
Raw Materials.....	\$.0005	\$.0014	\$.0007	\$.0044	\$.0022	\$.0007	\$.0017
Needles.....	.0039	.0017	.0034	.0106	.0012	.0011	.0037
Processing Labor.....	.0046	.0324	.0164	.0228	.0151	.0145	.0176
Total Cost per Injection.....	\$.0090	\$.0355	\$.0205	\$.0378	\$.0185	\$.0163	\$.0230
Intramuscular							
Raw Materials.....	\$.0005	\$.0014	\$.0007	\$.0044	\$.0022	\$.0007	\$.0017
Needles.....	.0144	.0078	.0191	.0141	.0061	.0386	.0167
Processing Labor.....	.0046	.0324	.0164	.0228	.0151	.0145	.0176
Total Cost per Injection.....	\$.0195	\$.0416	\$.0362	\$.0413	\$.0234	\$.0538	\$.0360

TABLE 4—SYRINGE COSTS—2 CC.; 5 CC.; 10 CC. SIZES—PER INJECTION

INJECTION COST—SYRINGE ONLY Syringe Sizes	HOSPITALS						Average
	A	B	C	D	E	F	
2 cc.							
Raw Materials.....	\$.0018	\$.0081	\$.0005	\$.0049	\$.0068	\$.0012	\$.0039
Syringes.....	.0238	.0116	.0171	.0533	.0080	.0113	.0209
Processing Labor.....	.0078	.0236	.0171	.0218	.0188	.0115	.0168
Total Cost per Injection.....	\$.0334	\$.0433	\$.0347	\$.0800	\$.0336	\$.0240	\$.0416
5 cc.							
Raw Materials.....	\$.0018	\$.0081	\$.0005	\$.0049	\$.0068	\$.0012	\$.0039
Syringes.....	.0385	.0204	.0348	.0544	.0302	.0265	.0341
Processing Labor.....	.0078	.0236	.0171	.0218	.0188	.0115	.0168
Total Cost per Injection.....	\$.0481	\$.0521	\$.0524	\$.0811	\$.0558	\$.0392	\$.0548
10 cc.							
Raw Materials.....	\$.0018	\$.0081	\$.0005	\$.0049	\$.0068	\$.0012	\$.0039
Syringes.....	.0346	.0284	.0720	.0488	.0126	.0222	.0364
Processing Labor.....	.0078	.0236	.0171	.0218	.0188	.0115	.0168
Total Cost per Injection.....	\$.0442	\$.0601	\$.0896	\$.0755	\$.0382	\$.0349	\$.0571

came from central supply accounted for 80 per cent of the injections and those that came from the laboratory, for 20 per cent, the labor cost in central supply was given an 80 per cent value and the labor cost in the laboratory a 20 per cent value to arrive at the total cost.

OBTAINING INJECTION COUNT

Three of the hospitals had detailed records available that could be used to determine the number of injections given. Hospital A had records for the entire year 1956. Hospital B had records for 74 consecutive days in 1956 and 1957. Hospital F had records covering 157 consecutive days in 1956 and 1957. In the remaining four hospitals, it was necessary to develop alternative procedures to determine the number of injections given.

At Hospitals C and E the injection

count was made for one calendar week during the course of the survey work. Hospital D made a count of injections for one calendar month. At Hospital G no data were available and it was necessary for the supervisory personnel of the hospital to estimate the injections given. Table 1 summarizes the number of injections given by syringe sizes. (See page 79.)

In order to compare the costs, a base period was established. This base period was the year 1956. Thus, all statistics and costs collected were converted to this year. Since the injection count was developed from seven different time periods, it was necessary to relate these counts to the patient days for the same time periods. With this relationship established it was possible to obtain the average injection per patient day. The average injections per patient day were then multiplied by the

total patient days for 1956, providing the total injections as shown in Table 1.

OVERHEAD COSTS

Overhead is normally considered applicable to any cost calculation. However, all of the hospitals did not develop overhead costs in the same manner, thus destroying comparability between costs. It was decided that only direct costs would be utilized in this report.

In the several hospitals where overhead costs such as supervision, utilities, floor space, maintenance and supplies were allocated to the central supply department, the per injection cost ranged from \$0.0069 to \$0.0182.

COST RECAPITULATION

Table 2 shows the total cost per injection. Hospital A is the lowest in total cost at \$0.0461 per injection. This

(Continued on Page 146)

Scholarships Help Them Recruit Nurses

This hospital is remedying the local shortage of nurses by a carefully worked out program of scholarships to students who can be expected to come to the hospital upon graduation and thus provide a continuing supply

SHIRLEY M. LINDBERG, R.N.

TWO years before Marion Memorial Hospital, Marion, Ill., was opened it was recognized that we might have considerable difficulty in obtaining enough nurses, since few graduates of our local high school went into nursing. There was no community hospital to guide them, and nursing was not among the professions discussed at the school on Career Day.

A member of the board of trustees for the hospital learned that there were local girls who would like to be nurses but, because of lack of finances, were not able to do so. Immediately, obtaining scholarship loans and grants became the most urgent duty of the board. A number of service clubs and interested individuals were contacted,

Mrs. Lindberg is administrator, Marion Memorial Hospital, Marion, Ill.
Condensed from a speech presented at the Tri-State Hospital Assembly, Chicago, 1957.

and the rough outlines of a plan began to emerge.

A committee was necessary to work out the details: the amount of money required in an average nursing school; the type of contract most likely to bring a new nursing graduate back to Marion Memorial Hospital; methods of selecting candidates; methods of granting scholarships, and a general statement of the program's purposes, which were:

1. To assist young girls in gaining an education in the profession of their choice.
2. To recruit nurses for the profession.
3. To provide a continuing supply of registered nurses for Marion Memorial Hospital.

The selection of the committee which, under the board of trustees, would be granted full responsibility

for the proper conduct of the program, was of the utmost importance. Our committee is composed of five congenial women, who do not necessarily always agree on details, but who have the interest of the program and its success uppermost in their own efforts. Two are school teachers (one of these is also a doctor's wife); one is a hospital board member and on the city recreation board; the other two are women who are active in the community. One of them is also on the recreation board. They were appointed by the hospital board and have been reappointed each year.

Just giving or granting a sum of money without definite obligations and terms of agreement for its proper use and repayment (if required) would never achieve the desired results, the committee felt. On the other hand, rigid regulations and obligations might frighten away some good candidates and eventually cause unhappiness or undue enmity toward the program, too. Our contract is one that binds each party (hospital and student) only enough so that each will benefit the most.

For example, if a student bitterly resents the requirement to return to Marion to work in the hospital, she will never be a good employee. She would be unhappy and so would we. If the student does not meet our requirements in any way and would not fit into our organization, to employ her would be unjust to her and to the hospital also. However, the committee felt that each girl should realize she has assumed a responsibility when she



Another recruiting measure at Marion was the formation of a training program for high-school age nurse's aides, known around the hospital as the "Buttercups." Here, the director of nurses instructs them in their responsibilities.



Feeding the patients is an important part of the training of the high school students who hope to be nurses.



Another technic that must be mastered by the students is the proper method of taking blood pressure readings.

is granted a scholarship, and that she should be required to make every possible effort to fulfill this responsibility.

The provisions of the contract as it was finally worked out are:

1. A scholarship loan in the amount of \$450 can be granted only to a girl who has been previously accepted by a school of nursing.

2. The money shall be advanced over a period of three years and shall be generally proportioned to tuition and school needs.

3. Upon completion of the three-year training period, and graduation from the school, the student shall offer her services to Marion Memorial Hospital for a period of 18 months, at the prevailing rate of remuneration then being paid for such services.

4. The student is bound and obligated to pay back at least one-half of the amount of the advances within a period of two years after graduation, interest free.

The contract further provides that if the student does not fulfill these provisions, the full amount of all advances shall be due and payable with interest at 6 per cent per year within three years from the date of the completion of the training period, or one year from the date of cessation of training should the student fail or otherwise neglect to complete such training and graduate.

Let's discuss these provisions separately.

1. The amount of \$450 was arrived at after considerable investigation, including collecting information from the many nursing schools around this area, and schools that Marion girls would be most likely to choose. The majority of these schools had different tuition rates, and this amount would cover the major expenses in

each of them for the full three-year period. This figure may have to be revised in the future if many more schools increase their rates. However, at this time it is still sufficient, and does allow some extra for unusual expenses.

MUST BE ACCEPTED BY SCHOOL

To avoid granting scholarships to girls who would not be acceptable to nursing schools, we have required the girl to bring evidence of acceptance by her school. When this is done we feel that the burden of selection of good nursing material is in the right hands, and our scholarships will not be endangered by mishandling. The schools are better equipped to evaluate and select their students, and this is as it should be. Our function is to help prospective nurses finance their education and in that way help prevent the loss of a good nurse to the profession, because of finances. We are not trying to prevent these girls from making their own selection of their school; we finance individuals, not schools. However, we do counsel with the girls and direct them to accredited schools, partially from a selfish point of view. We want to employ well trained and efficient nurses, and we are looking forward to the return of these girls. Then, too, we feel that it is in the best interest of the girl that she obtain the best training available for her own sake and that of her future career.

2. Since the majority of schools have tuition charges divided into yearly or semester amounts, the scholarship payments should be made at those times. No student should be given the responsibility of the entire amount to be husbanded over so long a time. As a general rule the schools will send expense statements directly to us, or

will give the statement to the student to send to us. Our checks are written to the school involved, not the student. In this way we can guard the balance and make certain that the correct amount is on hand at the time of need.

Also, if the full amount of the scholarship is not needed for school expenses, the entire \$450 may not be spent and the student has that much less to repay after graduation, or, when she discontinues training, both the principal and interest accrued are less and are more easily repaid.

3. This is the main provision that will continue to keep us supplied with nurses. You will note that we have said that the student shall offer her services, we did not say that she shall work here. This, if you will, is our loophole whereby both the hospital and the student are allowed some leeway. If the student would not fit into our organization, or if we do not have a position open at that time, the hospital is not obligated to employ this particular nurse. If we know that the student resents being forced to return to Marion (and some might feel this way) we can ease her mind, and prevent future troubles by not employing her.

For instance, one of our girls graduated last fall. We knew that she would not want to return to Marion, and would be most unhappy here if forced to do so, because her family had moved from Marion to the city where she was training. There was no longer any personal tie in Marion. We had also learned from her director of nursing education that this girl needed a great deal of supervision, and that she was not yet ready to be thrown on her own as she would be in a small hospital such as ours. She just was not ready to carry the amount of respon-



The "patient"—another student—looks amused as her fellow Buttercup checks her pulse and temperature.



Larry McCluskie, an aide in central supply, plans to enter nursing after his graduation from high school.

sibility nurses in small hospitals must carry. We did not employ this nurse, and she paid the full amount of her loan, plus interest, and everyone was happy.

Of course, each such case must be decided on its own merits; there can be no standing rule, and no precedent can be set. If the particular student wants to continue her education and her school says that she has the talents for nursing education or whatever further training she has decided on, again special arrangements are made to allow her to do so. In fact, we might continue to help her financially.

We are fortunate in being only 17 miles from Southern Illinois University, where many of the courses required for degrees are available. We are happy to work out a time schedule to encourage any of our nurses to take them. There is no reason these nurses should be employed in any way other than the way we employ others. They are on the same salary schedule with the same benefits the others receive, and will be treated in the same manner in advancement, discipline, discharge and so on.

4. It is the desire of the committee and the board that this program shall be continued as long as possible. If there were no provision for at least partial return of the loan, it wouldn't be long before there would be no more scholarships. By returning half of the loan, each recipient also knows she is helping to make it possible for another girl to enter nursing and benefit by having a scholarship loan.

Most of the scholarships were provided by local service organizations, and most of them used money from their educational funds. In many of these organizations there are rules governing the use of these funds and pro-

viding for some refunding. Because of this fact, also, it was deemed wise to ask partial repayment. We are fortunate in having enough interest in this program so that most of the organizations have agreed to keep the scholarship up to the level of \$450. In other words, after a scholarship has been used and the student has repaid half, the original donor will again add as much money as necessary to bring the scholarship back to \$450, which has been done by two organizations this last year.

CANDIDATES ARE INTERVIEWED

The committee is solely responsible for the selection of candidates. It is guided by results of several interviews by members of the committee and reports from the girl's scholastic record. It has also asked our director of nurses and me to interview each girl and express our opinions. The girl must apply for the scholarship by letter directed to the committee. In this letter she is asked to give her reasons for wanting a scholarship. The parents of the girl, as a general rule, are interviewed also to give us more understanding of the girl and her relations with the family. It is a generally accepted rule that the student should be a local girl, most likely to return to Marion. This does not rule out good prospects from the surrounding towns and rural areas, but the money comes from local people and clubs, and it is felt that the donors would prefer it to be used locally.

Selection of candidates is one area that is constantly under study, and we are much aware that good selection will be the key to final success or failure.

We now have a total of 18 scholarships available. All of them have been

used at least once. We have helped 23 girls enter training. Of this number 10 have not completed the course, seven have graduated, and six are in training at this time. Five of the graduates have returned to work at Marion Memorial Hospital, and four of them are still with us. The fifth one has married, is the proud mother of two babies, and will not be planning to work for some time. The two who did not return include the one I mentioned earlier and another who married while in training and with the permission of her school. Her husband lives in the city where her school is located, and she is of course remaining with him.

Of the six in training now, two will graduate in September and both plan to return to Marion; three will graduate in 1958, and the remaining one graduates in 1959. Of the 10 who did not complete training, four failed in classwork, three became engaged and were in schools that did not permit married students to continue, and three decided during the preclinical period that they really didn't like nursing as much as they thought they would.

These things tell us that we have been 48 per cent accurate in our selection of candidates; however, we did rely on the school of nursing to determine the scholastic abilities of the students, and I don't think we should be charged with the four who failed in classwork. But we are not entirely satisfied that we are doing as much as we can in making proper selection.

Because of our search for more nearly accurate selection methods, and because we had numerous requests from girls in high school for summer jobs and an opportunity to learn about nursing, we have developed a new program in the last two years that looks as though it will be of value

both to the prospective student and to the hospital.

After much deliberation, the director of nursing service developed a program that seems to meet the need. The plan formulated is similar to a nurse's aide program, except that some

duties aides are permitted to do are not included. The girls must be seniors in high school, or at the very least juniors, and must evidence a definite desire to enter nursing and if possible show some evidence of an effort to enroll in a school of nursing. She must

be at least 16 years of age. These girls meet every day for two weeks and are taught to clean and arrange patient units, make occupied and anesthesia beds, serve and remove patient trays, feed the patient, give baths.

At the end of this period the girls are given yellow pinafores with white blouses and are started on the nursing unit under close supervision. We have found that these girls are extremely alert and have learned quickly to do the tasks assigned them. We have had excellent results these last two years. The girls have won the hearts and favor of all the patients and nurses who dubbed our first group "the Buttercups."

One thing we have learned is that these girls who have entered nurse's training are still in training, whether they went on one of our scholarships or not (and some did not). These girls knew what they were going to run into in the patients' rooms and in all of their contact with illness and hospital procedures and policies. The Buttercups are not paid for their training period, but as soon as they are put on the nursing unit they go on the payroll at \$60 a month and are given their on-duty meal and laundry of the pinafore, which is supplied by the hospital.

We are trying to evaluate this program to see if we can require participation in it before a girl could be considered eligible for a scholarship. I have written to the directors of nursing education of all of the schools where former Buttercups are now in training and, with only one exception, they all said that the experiences the student gained as a Buttercup were extremely valuable during training.

The one director who did not agree felt that "nurse's aide" work was inferior experience, and she preferred girls who had not had it. She emphasized the need for good scholastic grades and more emphasis on the languages and other cultural subjects during high school. I cannot argue with her that these are extremely important but it is interesting to note that the student in her school gives the most credit for her ability to adjust in training and feel self-confident in a new situation to her experiences here. All comments from the students have been most encouraging; the only criticism was a mild one, concerning the slight difference in procedure, but the girl hastened to add that it was not difficult to change to the new method.

Patient Relations Director Builds Good Will by Helping Patients Understand the Hospital

AT EVANSTON HOSPITAL, Evanston, Ill., a director of patient relations is helping to keep patients happy and boost employe morale. The position was established here during the last year.

The director, Robert J. Nast, calls on as many patients as possible, with the exception of those in maternity, communicable disease or psychiatric areas. He presents an over-all picture of inpatient services, answers questions, and stresses certain hospital policies. He also is in charge of patient questionnaires, replying to the complaints and commendations contained in them, as well as analyzing results.

From the interviews and questionnaires, he prepares an interpretation of patient reaction for the administrative staff and forwards complaints and commendations to department heads and medical staff members. They often work with him to correct difficulties reported in certain areas.

The director's friendly calls have been welcomed by patients as evidence that the hospital is interested in their welfare. Many have asked questions about hospital costs, size of hospital, and size of staff needed, for example.

Patients were confused by some of the special examinations, the questionnaires showed. Formerly these had

been explained orally. Now simplified explanation sheets describe basic laboratory and x-ray tests, outlining what the patient is to do and what he can expect. These have been enthusiastically received.

The early waking time was a recurrent complaint, the director found. Now nurses on the day shift take temperatures and blood pressure, and dietary employes report to the floor kitchens later than they used to so that patients will not be disturbed by noise there. The change was made through the two departments, with administrative approval. Although it meant a larger nursing staff was needed during the morning, the increased comfort of patients and lack of complaints about early hours have made the new schedules worth while.

Other changes, such as pillow speakers for radios and TV sets, clothes hooks for bathrooms in an older section, and loudspeaker announcement of the close of visiting hours, have been made as a result of patients' suggestions to the director.

Patients' commendations also are used to advantage. Department heads use the comments, forwarded by the director, to strengthen and build employe morale.—EMILY W. STEBBINS, director of public relations, Evanston Hospital, Evanston, Ill.



The director of patient relations has to have tact and good training in hospital work, as Mr. Nast (right) has. Here he explains hospital policies to a patient to prevent any future misunderstandings.

The Purchasing Policy Shouldn't Just Grow

A hospital without a basic written policy that defines its purchasing practices in terms everyone can understand is leaving itself wide open to controversy both with its suppliers and within its own departmental organization

EDWARD H. HEYD

THE origin of a purchasing policy usually does not follow the popular concept that a policy is something established by careful planning to provide a specially designed course of action. In actual practice, policy is seldom laid out as a prescribed road to follow. Too frequently, instead, one finds oneself well along the road and approaching a fork. Without a predetermined destination, a decision is made to take one of the forks—many times depending on how one feels that particular day, how attractive the initial cost, how well liked the salesman, how appealing the F.O.B. hospital, 2 per cent discount terms, or a hundred other factors that may affect a sale.

MUCH IS LEFT TO CHANCE

To be sure, policy eventually is established. Many roads are traveled until habit, trial and error, or frequently an alert supplier willingly serves as a guide to a destination. Actually, a great deal is left to chance. We may come up with a course of action, but, as in the development of any habit, bad habits may be included just as easily as good ones.

The question is: Can we afford to let a purchasing program grow haphazardly? Can we let a plan for the procurement of supplies and services in our hospitals be dependent on second guessing, on personal likes and dislikes, on the character and temperament of the purchasing agent? Is it not management's responsibility to define the area of operation and ac-

tually establish basic policies, if we are to call them such?

Let us start topside. In most hospitals the board of trustees is a sincere, conscientious group performing many thankless tasks. We must remember, too, that there are few hospitals where boards function exactly alike. It has been my experience, however, that the hospital operating management must formulate and propose the procurement policy. With the best intentions, the board of a community supported hospital may find it difficult to agree to the principle, "Everything being equal, we'll buy locally."

The apprehension trustees feel about establishing such a policy is revealed in the way it is discussed. Many thought-provoking questions are asked, but a fantastic number of irrelevant ones may contribute confusion on the subject. In one instance, after a lengthy hearing at which the administrator had proposed the adoption of this principle because of an explosive local situation, he was told, "We don't want to make too many changes. You buy the best you can at the lowest price. We don't want to offend our many friends. There is a big job to be done here. You do what you think best, but don't cause any controversy."

This is not an isolated instance. If policy evolves from this type of discussion, it certainly lacks the basic principles and wisdom we like to believe is the foundation for policy making.

In this instance, the administrator may have been in error in making an untimely and inadequate presentation. It certainly is not politic to propose a policy when a sizable purchase is at

stake and personalities may be involved. Also, it is unlikely that a practical purchasing program can be developed from an isolated policy like this, regardless of its basic strength.

If we are to discuss policy, let us be certain we are talking about policy, about something that can be reduced to writing and that is generally and commonly understood. Let us be sure we can defend our position at all times, against all comers. We certainly are vulnerable when we leave our day-to-day operation to chance, to haphazard, habit-forming procedures, to casual conversations, or to the possible influence of unintentional personal bias—and call this policy.

CODE TO GUIDE SUPPLIERS

Many hospitals have a code, or some regulatory information, for the guidance of suppliers. These ground rules essentially establish primary policy. They state how the game is going to be played. It is especially important to remember that this game is not one to be played alone. All participants should be considered. The ground rules frequently call for:

1. A statement assuring all salesmen they will be treated courteously, equally and promptly.
2. The recognition that communications with suppliers go two ways, including a standing invitation to the supplier to make suggestions and tell his story if it has merit, but protecting the right of the purchasing agent to conserve his time and patience.
3. An invitation to all reputable and legitimate suppliers to submit prices and other data for equipment, supplies and services, consistent with the pre-

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vailing hospital standards, the institution's needs, and recognized and established specifications.

4. An outline of the procedure for submitting samples and bids.

5. The schedule of times purchasing office is open for interviews.

6. The suggestion procedure for out-of-town salesmen to arrange appointments.

7. The need for limiting costly, frequent and unnecessary solicitations.

Additional ground rules are helpful to assure a clean sale, and especially

to avoid time consuming and costly controversy between supplier and customer. There is nothing more futile or wasteful than an order fouled up in controversy between supplier, purchasing, receiving and accounts payable. To prevent this, the hospital should:

CHECKLIST OF PROCEDURES REQUIRING WRITTEN POLICIES

POLICIES must be laid down for the guidance of the hospital organization. They should explain:

1. The division of responsibility between purchasing, dietary and pharmacy, if the procurement function is to be divided, and the apportionment of record keeping and financial controls between purchasing and the business office. For example:

What are the specific responsibilities of purchasing, dietary and pharmacy (1) in receiving and filling requisitions, (2) in buying for their own use or others, (3) in approving and receiving deliveries, (4) in warehousing supplies, (5) in making internal distribution, and (6) in maintaining controls and inventories for staples, perishables and services?

APPROVING INVOICES

What are the responsibilities of purchasing and the business office in designating approval of invoices for payment, auditing inventory records, accounting for credits, and maintaining adequate statistical and financial records?

Is the purchase order designed, and a procedure established, for management to appraise the hospital's activity by reviewing the new items being procured and the dollars being committed?

Is the specialized "know-how" of all departments being used effectively?

What delineation of responsibilities prevents the overlapping of activities but develops the centralization of duties, without splitting hairs?

How can the special skills and abilities of the available employees be used to best advantage and still keep in mind an eventual master plan? (It is probably better to have

an 80 per cent practical working program than a 100 per cent paper organization that doesn't function.)

2. The desirability of promoting standardization of practices and equipment without sacrificing necessary flexibility.

Are standardization and flexibility laid down as institutional objectives with sufficient clarity to achieve the desired action from all?

How aggressively can standardization be pursued without limiting necessary freedom of action?

Who has the prime responsibility to sponsor a program of standardization?

When can standardization be justified without evoking the accusation of regimentation?

How can standardization be achieved with a maximum of flexibility in maintaining the minimum of items inventoried?

Who is the key man to promote greater flexibility in procurement and use of supplies?

3. The responsibility for determining the functioning of a system of requisitions, purchase orders, receiving tickets and inventory controls.

Have the basic organizational decisions been made which must precede the paper work or record keeping?

Who determines space allocation *i.e.* dollars saved in volume purchasing?

Does the purchasing agent have supervisory responsibility for general stores?

What are the security advantages and disadvantages for the same person to be responsible for receiving merchandise, authorizing payment, and distributing and purchasing it? The practical advantages and disadvantages?

Is the stores requisition an order,

or a request, to issue a certain number of specified items?

May the purchasing agent use his judgment in disbursing material? How much authority does he have?

Does the ordering department have the right—or is it a courtesy—to designate a source of supply?

To what extent must purchasing follow the suggestions on requisitions or purchase orders of the using department as to quantity, quality and source of supply?

SIGNING REQUISITIONS

Who is authorized to sign requisitions? Are some forwarded to a higher echelon for approval—if so, which ones?

What does an authenticated receiving ticket indicate—does it approve quantity, condition of shipment, approval of merchandise?

Who establishes pricing of inventory when there are several items with different prices? Is LIFO or FIFO followed—or both, or averages?

How is disbursement of items with measured shelf life controlled?

If there is an inventory catalog, is its primary intent to standardize and limit?

Who is responsible for keeping the catalog active and accurate?

Are preprinted requisitions being used effectively?

How are back orders for supplies controlled?

What is procedure for handling requisitions with back orders?

Who is responsible for reviewing the paper work in procuring supplies and services, and proposing new methods for obtaining more simplicity and greater efficiency?

4. The responsibilities of the hospital and its employees and staff members.

1. Indicate that orders are to be honored only when submitted on a hospital purchase order and when signed by a specifically authorized employee representing the hospital.

2. State when purchase order numbers are requested on packing slips,

outside cartons, correspondence, invoices, or at other times.

3. Stipulate the procedure for, (a) paying accounts (if it is to be the 10th of the month following receipt of goods; if payments are to be withheld pending receipt of goods; if in-

voice adjustments are to be made before payment is authorized); (b) taking discounts (if discounts are to be taken according to percentage on face of invoice regardless of allowable discount period); (c) receiving deliveries (if specified hours are set for general

TO AVOID WASTE AND ENSURE GOOD PURCHASING PRACTICE

Is there a clear understanding that the control or potential control over the negligent party seems to be the essence of liability?

What responsibility does this place on the purchasing department (or the hospital management) when using supplies and services when there is not complete agreement by the users?

Does this mean all requests from the medical staff have to be honored?

Does the purchasing agent have to buy exactly what is requested to avoid liability?

Does the buying of known "irregulars" or "seconds" indicate negligence?

Are "name brands" always a safe buy?

5. The attitude of the institution relative to its purchasing agent's accepting or refusing gifts and favors.

Is it mandatory to refuse all gifts and invitations?

Is a policy of moderation permitted at the discretion of the purchasing agent? What determines moderation? Who is to determine if discretion is in keeping with hospital attitude?

Is a possible intimate friendship between the buyer and seller recognized, and if so, how is it handled?

Does the size of the gift or the cost of it determine what is acceptable?

What are the advantages and disadvantages to the individual hospital of a purchasing policy that recognizes only an official, formal relationship with the supplier—or a personal, informal relationship?

6. The authority of the purchasing agent to negotiate and sign contracts.

Does the purchasing agent have full, limited, or no authority to ne-

gotiate and sign contracts in the hospital's name?

What items may be included in the purchasing agent's jurisdiction—elevator maintenance contracts, business machine service contracts, medical gas contracts, solution contracts, janitor supply contracts, carbon paper and typewriter ribbon contracts, surgical supplies, pharmaceuticals, fuels, construction contracts?

What determines the basis for the purchasing department to negotiate a contract—the item or service? The amount of money involved? The period of time covered in the contract?

7. The method of purchasing that is to be employed in the hospital.

Does the hospital buy price, quality, or service on impulse?

What items are bought on price? On quality?

How much part does local use and experience play in determining quality *vs.* the reputation of known name brands, or the influence of extensive advertising, or the price?

What is procedure for circulating information covering new supply items?

Is it possible for salesmen to speak directly with an operating department? How arranged? Who is seen?

How are technical services of suppliers brought to the attention of using departments?

Is buying to be on a strictly bid basis, and if so, who prepares the specifications?

What is the source of the specifications—Government? Testing bureau? Supplier? Own experience?

If buying is on a spot basis, how do suppliers ascertain hospital's needs? Is there a definite time for placing orders?

If there is a combination of the two methods, what is the basis for determining which will be used for what, and when?

Does the procedure for buying capital items differ from that used in procuring traffic items?

Who determines which buying procedure is to be followed and how are suppliers advised?

Who does the leg work to get all facts on the purchase of new items, and on what basis is the need determined?

Is it policy to procure samples and the opinion of using department?

Are new items furnished, as available, to using departments for opinions?

8. The procedure for maintaining and controlling inventory.

What is the buying cycle?

Who determines it?

How is it established for various items?

Is there a minimum stock level that calls for reorder? If so, who establishes it?

What items have a minimum stock level?

How is it determined that minimum stock items are still in use and will be reordered?

Who is responsible for inventory control?

Who spot-checks inventory?

Who authorizes adjustments in inventory records?

What system of adjusting records is used to transfer numbers in the storeroom to dollars in the business office?

Whose responsibility is it to show money invested in inventories or in orders placed?

Are inventories charged against major using departments such as dietary or housekeeping, or is there a blanket stores account?

merchandise, dietary supplies, pharmaceuticals, perishables).

4. State if special delivery, air express, and c.o.d. shipments are not to be accepted unless authorized in the purchase order; if other delivery charges are to be prepaid and itemized on the invoice; if supplier is to select the means of transportation; if all orders are to be f.o.b. hospital unless otherwise stated.

5. Inform how emergency orders are to be received when the receiving platform is closed, who is authorized to sign for such orders, and who is responsible for expediting internal delivery.

6. Anticipate the many other local problems required to get the merchandise from the supplier to the point of use, and have a plan to meet the situation.

MAKE JOBS SIMPLER

The foregoing is external policy. For the most part, good external relations with suppliers are governed by a stated, comprehensive policy of public and community relations. Such a policy, incidentally, is applicable not only to purchasing but to the entire hospital operation. A delineation of responsibility makes good sense, and, as any set of reasonable and practical ground rules does, saves a lot of wear and tear on the personnel involved. Today, when the payroll dollar is so important, economy of effort is a significant item of cost. We have to make all jobs less involved, with a minimum of frustration. We have to find ways to save time.

Let us look now at internal purchasing policies, and the relationships of the purchasing department within the hospital. This is the area where dollars are saved and where real administration and management are needed. This is where the great challenge exists today. Here is an opportunity for developing and implementing fundamental hospital economies, for contributing to improved employee morale by suggesting labor saving ideas, and for achieving personal satisfaction in a job well done.

The first consideration in looking at the purchasing agent's job is to determine responsibilities and duties. Here is a description of his duties as it appears in the book, "Job Descriptions and Organizational Analysis for Hospitals and Related Health Services:"*

"Administers and directs program to purchase supplies, equipment and serv-

ices at most favorable prices consistent with quality, quantity and efficiency. Assists in establishing requirements for items or services to be procured, and develops standard specifications. Determines best method of purchase and directs procedure for procurement, inspection, and payment. Supervises storage, control, and issuance of materials. Maintains contacts with sources of supply, or their representatives, to keep informed of price trends, availability of supplies, new items and reliability of suppliers. Performs related duties."

In the same job write-up there is a description of work performed. One sentence in this statement says, "Attends hospital staff meetings to assist in coordination of purchasing services with other hospital services." This is the most important statement in the description. It should be elaborated and stressed. There are many basic, important policy functions in the explanation of this sentence. It opens various new fields of activity to the purchasing department.

There are two basic forms of organization in purchasing. In one, the purchasing function is purely a staff responsibility. In the other, it assumes the authority and duties of an operating or line department. As a staff function, the purchasing department has a clearly defined responsibility to recommend, advise or suggest. Despite the deliberate limitation of authority to direct, purchasing, as a staff duty, has the responsibility to be aggressive in its investigation and actions, and to use initiative in proposing better and more economical ways to do the job. In addition, it has the accepted right of appeal to top management if it believes its suggestions are ignored to the detriment of the institution's purposes.

Specifically, the purchasing department has the responsibility of a specialist on the management team, to serve as adviser to the administrator and department heads for all procurement matters. Purchasing is the authority, an expert in all matters concerning supplies and services, and may even be authorized to represent the administrator on these matters.

The purchasing department has the

*Job Descriptions and Organizational Analysis for Hospitals and Related Health Services. Prepared in cooperation with the American Hospital Association. U.S. Department of Labor, Bureau of Employment Security, U.S. Employment Service, Occupational Analysis Branch. U.S. Government Printing Office, Washington, D.C., 1952.

responsibility to anticipate the needs of the operating departments and to make suggestions even before assistance is requested. It is prepared to lead the way, not just follow. The purchasing job, in this organizational pattern, obviously cannot be done by sitting in an office handling time consuming routines. It is an active and creative job requiring the purchasing agent's presence at the point of consumption. He has to know specifically what supplies and equipment are being used, as well as exactly how they are being used. He cannot assume the book is being followed. To be alert constantly to less expensive but adequate or better substitutes, he has to be acquainted intimately with the situation.

DEPARTMENT HEADS MUST COOPERATE

Without a basic policy to outline the purchasing agent's duties within the institution and define his interdepartmental relationships in the organizational plan, controversy is inevitable. The departments definitely must understand that initiative and the right to ask questions and make suggestions are requirements of the purchasing job. In fact, the management team, including department heads, looks to the purchasing department for advice and recommendations in the solution of their problems. In return, the purchasing department expects cooperation and open-mindedness from the operating departments when reviewing new proposals or when participating in the investigation of a procedure.

The principles of this program are generally a lot easier to define than to implement, because fundamentally they require a long-range selling job—persistent education. To attain mutual understanding, all concerned must be assured that the inherent rights and duties of their jobs are secure, and that there is no overlapping of responsibility. Despite the readily recognized expediency and advantage of using the full potential of the purchasing department, unfortunately there is often some apprehension in some of the departments. Adequate topside preparation, assurance and encouragement are essential to alleviate such insecurity and doubt. Too frequently, purchasing is given a pat on the back and told, "It is a fine idea. Try it!" (If it works, we can take credit for it. If it starts a rhubarb, I wasn't in favor of it anyway!)

The first step is to affirm in detail the position and function of purchas-

ing in the official hierarchy. The job can be made extremely simple, and everyone made much happier, by agreeing to the basic policy in advance.

Too few hospitals have active standards committees or personnel specifically assigned to methods improvements. While the nature of these two activities varies widely, the purchasing department can play an important part in both areas. On a limited basis, the purchasing department can assume the initiative—be the catalyst to start the thinking behind these activities. The opportunities are unlimited. There is an ever-growing appreciation of the need for more and better standardized procedures and methods studies. The lack of a sufficient number of adequately trained purchasing employees to seize this opportunity is a problem. But perhaps even more of a problem is the failure of management in many instances specifically to assign these duties to the purchasing agent, if necessary as a part-time job, or as an added one. Once started, the importance and need for both will be self-evident, even to the point of overcoming one of the major obstacles—the apprehension of operating department heads that they may lose final responsibility for the activities within their respective areas.

There is also an organizational pattern in which a purchasing department may have an operating or line department's duties. This setup gives purchasing immediate direction of supply and service procurement. However, even here minimum policies are required to assure a truly effective and economical operation. As a line function, purchasing probably requires less finesse and persuasion to ensure an early understanding of its rôle on the part of the hospital organization. It can always use the "big stick" to make its point! Inevitably in this case, however, the interdepartmental relationships in the long run would not be happy. There probably would be a much greater need for a standards committee, or an arbiter, in this pattern than when the purchasing department is a staff function.

The need for an over-all philosophy of basic internal organization, with particular emphasis on purchasing, should be apparent. There are many details involved which require policy decisions to get the program started. Implementation of the details will reflect the caliber of the personnel and the strength of management's conviction.

The most intelligent personnel, if possessed with selfish motives, will never do the job despite the leadership or directives from management. There is a much better chance the job can achieve reasonable success by less gifted, but forward looking, department heads.

The assorted details in the proper setting will fall into place quite readily after management makes the key decision outlining the rôle of the purchasing department within the organization and its relationship with other departments.

Be Cautious About Investing in Expensive, Unnecessary Gadgets, Hospitals Are Warned

SOLACE for the harassed administrator is offered in an editorial entitled "Expensive Apparatus" which appeared in the *Journal of the American Medical Association*.

One of the forces tending to increase the cost of medical care today, the editor writes, is the existence of an endless variety of apparatus that has, or might possibly have, some use in rare cases. The introduction of such apparatus, involving initial laboratory research followed by engineering development, may itself be extremely expensive. But after it has been acquired by an institution there may still be surprising problems of operation, repair and storage.

To the original cost of elaborate diagnostic equipment, the editorial continues, so much may be added in the way of necessary housing, shielding, plumbing, filtering and special power supplies that serious consideration must be given to the cost as compared with the value of the anticipated information. An example is furnished by the recent complaint of a staff member in a large and especially progressive hospital. Partly because the staff was genuinely eager to lead in every scientific advance, partly because there is constant pressure from patients who study therapeutics in lay magazines, and partly because this physician had had especially scientific training and was adept at electronics, he was obliged to construct a formidable apparatus for one group of specialists. Let the instrument be referred to, for convenience, as a metagrabolograph. Clinical reports in praise of metagrabology, some of them by authors who clearly did not understand their own mathematics, were appearing in the journals. An atlas of metagrabograms had been printed. Its bibliography listed 700 references to recent European literature. Hopeful manufacturers were unveiling their first models in this country, and specimens were

being exhibited at conventions. The challenge could not be ignored. "I gave the idea a thorough trial," said the physician. "Our apparatus had at least 40 tubes and a hundred controls. My technicians refused to touch it."

He satisfied himself that neither this apparatus nor anything else based on the same principle could help to determine the prognosis or guide the treatment of the disease in question. He stopped using it, but anticipates trouble, as do some of his colleagues. "I foresee," said one of them, "the usual percentage of uncritical papers appearing in the literature, declaring that the idea has merit, and proving nothing." There may even be a period during which a physician will be suspected of incompetence or accused of carelessness if he cannot swear that he ordered a metagrabologram. If a well known commentator can complain to the nation because the alleged benefits of a so-called cancer remedy were withheld from a dying senator, what might such a person not do if some physician denied a sick general the help of metagrabology?

SOMEONE MUST STAND FAST

In conclusion, the editor writes, it appears that there is a place in medicine for investigators who have the courage to publish negative results, who patiently correct errors that have appeared in print, who question all things and hold fast to that which is good. There is a need for cautious organizations like the scientific councils of the American Medical Association. Someone has to stand fast through bursts of pseudoscience, especially those directed to the public. Unless the medical profession continues to support conservative and critical scientists, the number of expensive gadgets that a hospital must own will increase without limit, and so may the cost of medical care.—MALCOLM SMITH, *Richmond Memorial Hospital, Staten Island, N.Y.*

Equal Pay for Equal Jobs Is a Good Rule

The principle of paying comparable wages for comparable jobs is useful not only to check the consistency of each hospital's wage pattern but also to determine whether all hospitals within a given area are on an equal basis

JOHN H. HOLMGREN

METHODS of establishing an equitable salary plan, analysis of jobs, and development of job descriptions have been studied in the first two articles of this series. This month, Steps 4 and 5—how to rate jobs and develop classification plans and the methods of making a community salary survey—will be discussed. The concluding article in the October issue will be concerned with the establishment of salary rates.

Step 4 consists of rating jobs against one another. For most hospitals, the ranking method of rating jobs is recommended. Two other rating methods, the factor comparison method and the point system, are both used extensively in industry, but it is believed that for the purpose of hospital personnel administration and this manual, the ranking system is less complicated, less technical, and less expensive to administer than the other known systems.

To complete the rating of jobs, the coordinator studies job descriptions and selects a group of key hospital jobs.¹ The duties and responsibilities

of the key jobs should be well known to the coordinator and their salary rates should be in alignment with those of similar jobs in other area hospitals. The coordinator ranks such key jobs from the highest ranking job to the lowest.

The key jobs are used because the responsibilities and rates of such jobs usually are well established. When the list is finished, the ranking order of key jobs will serve as a basis against which the remainder of the jobs in the hospital are rated. The key list becomes the job rating list. Such ranking becomes a primary aspect of the process of job evaluation.

One method ranks all jobs by considering each job separately as a whole without regard to its parts, and plac-

ing it in a relative rank with others, preparing a ranking list in the order of difficulty.

A suggested method of modified job ranking ranks key jobs on the basis of how much education, experience and responsibility are required for each job, assigning the different degrees of each of these factors as needed in each job to help determine the relative rank of each job. For example, the job of clinical instructor may rate four years of college and three years of combined teaching and nursing experience. The job involves considerable responsibility for costs, safety of others, supervision exercised, and patient care. A general staff nurse may rate lower in the ranking of key jobs because this job requires less education, less nurs-

FIG. 1—TABLE OF FINAL JOB RANKINGS
Key Jobs
(excluding department head jobs)

No.	Job Title	Rating by Factor						
		Educ. in Years		Related Exper. in Yrs.	Degree of Responsibility*			
		H. S.	Coll.		Cost	Safety	Supv.	Patient Care
1.	Clinical instructor.....	4	4	3	Cons.	Cons.	Some	Cons.
2.	Lab technician.....	4	2	2	Cons.	Cons.	Some	Cons.
3.	Staff nurse, general.....	4	2	1	Some	Cons.	Some	Cons.
4.	Cashier.....	4	0	2	Cons.	Little	Little	Little
5.	Carpenter.....	4	0	2	Some	Some	None	Little
6.	Ward clerk.....	4	0	1	Some	Some	Little	Some
7.	Housemother.....	4	0	1	Some	Some	Some	None
8.	Janitor.....	0	0	2	Some	Cons.	None	None
9.	Maid.....	0	0	1	Some	Some	None	None
10.	Kitchen helper.....	0	0	1	Little	Some	None	Some

*Degree of responsibility for costs, safety of materials, equipment, and safety of others, supervision exercised, and responsibility for patient care. Degrees expressed as none, little, some, or considerable (cons.).

¹Most ranking plans suggest using a committee of persons representing management and employees to rank key jobs, but this is considered time consuming and more subject to delay in completing the ranking. It may not necessarily provide greater accuracy than having the job analyst develop key job rankings.

The author is business administrator, central office, Sisters of St. Joseph Hospitals, Wichita, Kan.

This is the third of a series of articles by Mr. Holmgren covering methods of determining fair salary rates. The final article will appear in the October issue.

ing experience for entrance on the job, and less responsibility for costs, safety of others, supervision exercised, and patient care. No consideration is given to existing rates paid key jobs in this step.

The application of this method of job ranking of key jobs is shown in Figure 1 on the preceding page.

When the table of key rankings has been prepared, the coordinator prepares a second list showing the same job titles by ranking order and adding a further column for rates paid key jobs as follows:

**FIG. 2—TABLE OF JOB RANKINGS AND RATES
Key Jobs**

No.	Job Title	Present Salary Paid (Monthly)
1.	Clinical instructor.....	\$400
2.	Lab technician.....	350
3.	Staff nurse, general.....	240
4.	Cashier.....	220
5.	Carpenter.....	200
6.	Ward clerk.....	190
7.	Housemother.....	200*
8.	Janitor.....	175
9.	Maid.....	130*
10.	Kitchen helper.....	150*

*Rates not in rank order.

As shown in Figure 2, the rates may not all be in ranking order. The asterisks indicate the rates that are out of line and must be adjusted through a check with the department head involved and the approval of the administrator. Final salary rates are further checked against rates found in other hospitals when the inter-hospital salary rate survey is made.

Following the ranking of key jobs, the remaining jobs to be evaluated are compared with the key jobs and their relative position on the list determined. For example, the coordinator may decide that nurse's aide should be ranked somewhere between janitor and maid. The salary rate for nurse's aide would later fall somewhere between \$175 and \$130 per month, when the final salary plan is developed.

Internal consistency of the different jobs in terms of their relative value to the hospital should be translated into internal consistency in terms of dollars and cents. If the office clerk is rated higher in the job ranking scale than the utility man, the office clerk's salary should be higher. To achieve external consistency with other hospitals in developing the pay plan so that jobs compare in rate with rates paid elsewhere, the interhospital rate survey is made following the hospital ranking study. The two procedures,

job ranking and a survey of outside rates, form the basis for the establishment of the pay plan.

Simplicity and speed are two of the advantages discussed by most writers in discussing the ranking method of job evaluation.² It takes less time and expense to develop and use this system than other methods. Also, it is easier administratively to explain the system to employees.

One writer recommends first ranking all jobs in an individual department in order of their importance and then combining departmental rankings in a cross-hospital ranking.³ However, it may be more objective to consider each job as a unit of the entire hospital to eliminate departmental bias and traditional thinking as well as the influence of personalities on the importance of the job.

Organization charts will prove helpful in considering the differences in responsibilities between jobs in each department and their relationship to the span of supervisory control.

Tables of ratings should be made a matter of record for the administrator's office, and each department head should sign and approve the final ranking of the jobs in his department. Reranking of jobs because of changes or revision in job content, or for other reasons, may be made later by the same job analyst. If so, a record of the change should be placed once again in the file. In all cases affecting the ranking of jobs, or the establishment or change of salary rates, the coordinator should check and obtain the approval of department heads concerned as well as the administrator. This will serve to develop a cross section of evaluation as well as help "sell" the program.

Care should be exercised by the coordinator in spacing the salaries of the rated jobs. The gaps between each job are not necessarily equal, i.e. the difference between jobs A and B may be \$25 a month, but that may not be true of jobs C and D. To check the validity of existing salary rates and the spacing between rates paid for one job as against another, a comparable wage and salary survey is made in the area. A rate survey may cause changes in the final rankings, when the coordinator checks community rates with department heads and the administrator.

²Patton, John A., and Smith, Reynolds: Job Evaluation, Homewood, Ill., Richard D. Irwin Inc., 1952, p. 31. Bailey, Norman D., Hospital Personnel Administration, Chicago, Physicians' Record Co., 1954, p. 150.
³Bailey, Norman D., Ibid., p. 150.

This may be because outside rates indicate the hospital is paying more or less for selected jobs than the other hospitals.

The basis for changes in job ranking may be the prevailing rate in the community. It is true that the prevailing rate is the "competitive" rate but this influence should be secondary to the principle of holding the proper relationship of rates *within* the hospital, job for job. It is more important in some ways to pay less for a job than another hospital and maintain fairness in the hospital pay plan than to meet competition but have rates which lack soundness, conflict with each other, and cause internal employee dissatisfaction. Each hospital has an obligation to all its employees to maintain a consistent and impartial pay plan.

COMMUNITY SALARY RATE SURVEY

Many hospital administrators may recall a problem arising where a given salary rate in the hospital is questioned as being too low. When the query is brought up by a department head, as, for example, the director of nurses, a hospital administrator almost instinctively reaches for the phone to call "Brown over at Centerville Hospital," 30 miles distant, or "Gray over at Plainview Hospital," 25 miles away. "What do they pay?" he asks himself. "Are we too low?"

Comparable wages for comparable jobs is a basic job evaluation principle in personnel administration. Not only should this principle be used as a criterion in checking internal consistency within the hospital, it should also be used to see that the hospital is not "out of line" with other area hospitals, in the manner in which it compensates for given jobs. To pay lower salaries is to lose competitive status, particularly in a community that has a hospital personnel shortage.

Having prepared job descriptions and knowing the content, the degree of responsibility, and the training and experience requirements of each job, the coordinator may next approach a community wage and salary survey. This is Step 5 in the review. Such a survey requires a visit to at least three hospitals in a 30 to 50 mile radius to obtain the wages and salaries paid for the same jobs in other hospitals.

Geographical distances and number and kind of hospitals considered will depend on whether the area is rural or highly urbanized. Where two or

three hospitals operate within the city limits, there will be less need to travel 30 to 50 miles to contact other general hospitals, clinics or public health centers for wage data.

It is well for the coordinator (or whoever undertakes the community wage survey) to arrange for interviews with other administrators or bookkeepers well in advance of actual visits. Appointments should be made by letter or telephone call, explaining the nature of the survey and the fact that the interview will be made to determine:

1. Actual salaries paid in each job classification showing the number of personnel paid by specific rate.
2. Salary rate ranges, if any, for the job classifications of interest to the surveyor, and hours of work applicable to each range, weekly.
3. Hours of work in each job classification, and whether jobs include any allowances, such as free meals, which would be converted to a cash value and added to the rates per month, or per week or hour.
4. Job content of each job for comparison purposes.

Whenever possible, the coordinator should make sure that the jobs discussed in each hospital are, in fact, the same as those he is attempting to establish and rate in the home hospital. If the cook at neighboring hospital "X" is the first or dinner cook, and if his work week is 48 hours, and if he works under the supervision of the dietitian, then the coordinator can use the salary rate paid at "X" hospital for comparison with the home hospital's cook as a comparable job. The job content is close enough to be almost identical and the work week, 48 hours, is the same. If, however, the work week were 40 hours, the salary given would need conversion to the 48 hour week to standardize comparison data with the home hospital's salary schedule. To do this, the following formula is suggested:⁴

Cook: 40 hour week = \$250 month
48 hour week = \$302 month

Predetermined Schedule of Hours per Week

40 hrs. = 173.3 hrs. mo.
44 hrs. = 190.7 hrs. mo.
48 hrs. = 208 hrs. mo.
 $\$250 \div 173.3 \text{ hrs.} = \1.45 per hour
208 hours times \$1.45 per hour =
\$301.60 month on 48 hour week.

In the foregoing schedule of average hours per month based on hours per week, the average hours have been

⁴Bailey, Norman D., op. cit., p. 173.

**FIG. 3—SALARY SURVEY
Home Hospital**

Job Title	Hrs.	Hospital A (50 bed) Salaries Paid	Hospital B (100 bed) Salaries Paid	Hospital C (300 bed) Salaries Paid	All Hospitals Salaries Paid*
Cook.....	48	1 @ \$250	1 @ \$225 1 @ \$215	1 @ \$285 1 @ \$275	1 @ \$215 1 @ \$225 1 @ \$250 1 @ \$275 1 @ \$285
Median salary.....		\$250	\$220	\$280	\$250
Average salary.....		\$250	\$220	\$280	\$250
Rate range.....		(\$225-\$300)	(none)	(\$250-\$325)	—
Asst. cook.....	48	1 @ \$225	1 @ \$270 1 @ \$165	1 @ \$275 1 @ \$210 1 @ \$185 1 @ \$200	1 @ \$165 1 @ \$185 1 @ \$200 1 @ \$210 1 @ \$225 1 @ \$270 1 @ \$275
Median salary.....		\$225	\$227.50	\$205.00	\$210.00
Average salary.....		\$225	\$217.50	\$217.50	\$218.50
Rate range.....		(\$175-\$225)	(\$165-\$270)	(\$225-\$275)	—

*To use in checking against home hospital rates.

developed by taking several years and statistically obtaining the averages shown.

When the coordinator has completed visits to the area hospitals, he should have sufficient data to determine the average (or median) salaries paid in each job classification in the hospitals surveyed. Such averages can then be used to compare with the existing or proposed salaries to be paid in the home hospital. The partially completed area salary survey might appear as shown in Figure 3.

The median rate is generally used to obtain the measure of central tendency in a group of salaries, as a comparison against the rate paid for the same job by the hospital making the survey. The arithmetic mean average salary rate is used where only a few monthly salaries are obtained or where there are no extremely high or low rates. Both median and average salaries are given in the foregoing illustration. However, the point is demonstrated that where several extreme rates are given for a job as in the case of Hospital C, "Assistant Cook," the median is a more indicative comparison or control figure to use in evaluating against the hospital rates of the hospital under study. The median is less subject to the distortion of extremely high or low rates.

Thus, in developing salary rates, the median of the rate range should be based on the median rates obtained by surveying other hospitals in the area. In a five-step range, Step 2, or the third increment, would be the median

figure that should be compared to the median rates paid for the same job in the other hospitals. To cite from the example of the salaries paid cooks (Fig. 3), of the five rates paid the job of cook, \$250 a month was the median rate. Therefore, consistent with other rate ranges in the pay plan to be established, the median rate for the home hospital should be at or about that figure, \$250 a month. The rate range might look something like this:

Minimum.....\$230 month
1st step..... 240
(Median) 2d step..... 250
3d step..... 260
Maximum..... 270

Some hospitals do not have a defined pay plan which limits the minimum and maximum rates to be paid given jobs. In the foregoing examples, however, the lowest and highest salaries paid were shown as a rate range, whether defined or not in the pay plan of the hospitals surveyed.

The rates shown in Figure 3 indicate the need for obtaining actual paid salaries instead of rate ranges alone. Hospital A, for example, indicates an established rate range for assistant cook as \$175 to \$225 a month, but the actual salary being paid is at the maximum of the rate range. The actual rate paid is more indicative for wage comparisons because it is a truer competitive rate for a salary survey check, and it facilitates the determination of average rates paid.

Because of the existence of part-time or "relief" workers in hospitals, it is suggested that part-time hourly

rates receive attention for comparison with part-time hourly rates paid in the home hospital, for both professional and nonprofessional personnel. The registry or private duty hourly or daily rate is usually paid registered nurses for several days per work week short of the 40, 44 or 48 hour work week established for nurses in each community. For nurse's aides, kitchen helpers, and the lesser trained categories, the part-time rate may be higher per hour than the minimum hourly rate paid those on a full work week, to compensate for the part-time worker's shorter hours, less desirable shifts, transportation and meals expense.

The trend appears to be away from establishing a single hourly rate for this group of employees without any deviation or allowable increases for performance on the job. Rather, to help eliminate turnover and hold valued part-time workers, many hospitals have been following a part-time hourly rate range, as for example, with kitchen helpers, 60 cents an hour (minimum) to 90 cents an hour (maximum). An important consideration in this respect is that a part-time worker's rate should not be higher than the maximum rate paid full-time hourly workers on a rate range pay plan. The reason for this is that the full-time worker is a primary employee in the hospital and is making a relatively more important contribution than the part-time worker.

Another important area that should receive the attention of the surveyor is the shift differentials paid registered nurses and other professional personnel. Some hospitals may follow an accepted community rate range for R.N.'s but pay a higher rate for the evening (3 p.m. to 11 p.m.) shift differential, or the night (11 p.m. to 7 a.m.) shift differential. This then becomes a competitive factor in quoting take-home pay to prospective professional applicants. Unless hospitals work together through a hospital council or similar organization to maintain comparable premium payments for shifts, standard hours per week, and comparable salaries, one hospital may finally force up the rates of the others in the area, resulting in higher payroll costs for all of the hospitals.

For jobs involving skilled crafts, such as carpentry, plumbing and electrical work, it is suggested that the wage data of the local construction industry would be more helpful and

more extensive than that found in nearby hospitals. Other industrial types of jobs found in hospitals, such as maintenance and engineering jobs, laundry operators, and so forth, should also be checked against local wage rates for the same skills.

The sole hospital in a large geographic area may need to get in touch with related medical and public health facilities, clinics and private physicians in the area to obtain local comparisons.

FRINGE BENEFITS

The area survey of wage rates in other hospitals should include a survey of the perquisites, allowances or, as sometimes called, "fringe benefits," established as personnel policies of the hospitals surveyed. Such employee benefits include those in effect for vacation, sick leave, holidays, meals and laundry, and other employee privileges.

Such benefits are called "fringe" benefits because they exist as privileges and gratuities bordering the wage and salary compensation plan. They are added compensation for services and for work performed by employees. They are becoming more and more important as a part of an ever-expanding personnel benefit program expected by many employees of hospitals as a corollary of benefits received by industrial employees.

One example of the importance of obtaining factual information on benefits in a wage survey is provided in considering a survey hospital where a free meal is given all employees. The cash value of such meals should be added to the salary rates of each job in order to develop a realistic comparison figure for check against the home hospital salary rate. The American Hospital Association's yearly salary survey indicates the cash value of meals to be added to monthly salary figures.⁶ This yearly survey, available from the American Hospital Association, includes statistical summaries developed by state and regional areas and by type position as tabulated from more than 3000 questionnaires from member hospitals.

In this connection, it is interesting to note that the trend appears to be away from providing free meals for employees. Instead of free meals, which are not usually appreciated by employees, it is "better policy to pay a full wage comparable with that paid else-

where for similar employment and to make a cost charge for meals."⁶

Although the value of vacation, sick leave, and holidays would not be converted to cash to use in an adjusted monthly salary figure, maintenance, including room and board (or meals alone), is a basic benefit usually requiring such conversion. This is necessary if the interhospital survey data are to reflect a proper "price tag" assigned by the hospital to a job where such benefits are given in addition to salary. This same conversion adjustment should also be made for the home hospital salaries for board and room (or meals) and converted to cash and added to the quoted or payroll salary figure to be used as an adjusted salary for average or median comparison.

A checklist of personnel policies and practices is shown in the personnel section of "Elements of Hospital Operation" available from the U.S. Public Health Service and published July 1, 1950.⁷

In summary, to assist in determination of hospital salary rates, a community wage and salary rate survey is made following the establishment of job descriptions. The surveyor checks the actual payroll salaries paid in each job classification, using the home hospital job write-ups as a basis for comparison. Salary rate ranges, hours of work, and final median salary rates are entered on survey work sheets to use in developing the home hospital salary rate plan. In addition to salary information obtained from other hospitals, information should be obtained on rates paid for part-time workers, and also on shift differentials and fringe benefits.

A check of local factories and firms, employment agencies, and medical and public health agencies may be necessary to obtain sufficient data for rate comparison purposes. The objective of the survey is to discover minimum hiring rates, average earned rates, and additions to income comparisons involving shift differentials and similar "extras."

⁶MacEachern, Malcolm T.: *Hospital Organization and Management*, Chicago, Physicians' Record Co., 1947, 2d Edition, p. 507.

⁷American Hospital Association, *Elements of Hospital Operation*, Washington, D.C., Federal Security Agency, U.S. Public Health Service, 1950. Reprinted from *Hospitals*, J.A.H.A., edited by Sam O. Gilmer Jr., hospital consultant, and prepared under the direction of John R. McGibony, medical director, Division of Medical and Hospital Resources.

⁸American Hospital Association, *Hospital Salary Survey, 1954* (Chicago: American Hospital Association, 1954), pp. 50.

ABOUT PEOPLE

Administrators

Richard D. Vanderwarker has been made vice president and general manager of Memorial Center for Cancer and Allied Diseases, New York. He was formerly general manager. Mr. Vanderwarker went to Memorial as administrative director in April 1952, after serving as director of Passavant Memorial Hospital, Chicago, for four and a half years. He is a former associate director of the hospital administration program at Northwestern University, from which he was graduated in 1950. A graduate of Cornell University's school of hotel administration, he held various hotel administrative posts before entering the hospital field. It was also announced that **Lawrence Dickovick** has been appointed assistant general manager of Memorial Center. Mr. Dickovick was formerly associate administrator of the Community Hospital at Glen Cove, N.Y. He is a graduate of the 1954 class in hospital administration, School of Public Health, Columbia University.



Richard D. Vanderwarker



Robert A. Molgren

Robert A. Molgren has assumed the position of administrator of St. Luke's Hospital, Kansas City, Mo. He had been administrator of the University of Kansas Medical Center since 1952. At St. Luke's he succeeds the late **Leslie D. Reid**, who died in March. Mr. Molgren is a graduate of the hospital administration course at the University of Minnesota. He has served as administrative assistant at Kahler Hospital and Mayo Clinic, Rochester, Minn.; administrative resident at Bronson Methodist Hospital, Kalamazoo, Mich., and administrator of Allen Memorial Hospital, Eldorado, Kan., for four years. He is president of the Kansas City Area Blood Bank, and a trustee of the Kansas City Blue Cross. He also is a past president of the Kansas Hospital Association, and a former chairman of the administrative council of the Kansas City Area Hospital Association.

Dr. E. Dwight Barnett, director of Columbia University's Institute of Administrative Medicine, has been appointed medical superintendent of Palo Alto Hospital, Palo Alto, Calif., effective next February. Upon completion of the Stanford University portion of the combined Palo Alto-Stanford Hospital Center (now scheduled for September 1959) Dr. Barnett will have charge of the entire administration of the combined hospital. It is understood that he will also hold academic rank at the university. Before going to Columbia University in 1952, Dr. Barnett served at Harper Hospital, Detroit, for six years as associate director and director. He is a trustee of the American Hospital Association, a member of the Blue Cross Commission, and a past president of the Michigan Hospital Association.



Dr. E. Dwight Barnett

Stewart Marylander has been appointed administrative assistant in charge of personnel at Cedars of Lebanon Hospital, Los Angeles. Previously he was administrative resident at Mount Zion Hospital, San Francisco.

A.H.A. SERVICE AWARD

John H. Hayes, former director of Lenox Hill Hospital, New York, and a past president of the American Hospital Association, will receive the A.H.A.'s Distinguished Service Award at its annual convention in Atlantic City, N.J., October 2. Mr. Hayes is vice president of the National Health and Welfare Retirement Association, Inc., and former director of the Commission on Financing of Hospital Care. He has served as president of the Hospital Association of New York State and president of the Greater New York Hospital Association. He has been active in nurse recruitment, and still holds the chairmanship of the National League for Nursing's Committee on Careers. He was associated with Lenox Hill Hospital from 1926 until his retirement in 1953.



John H. Hayes

T. Joseph Hogan has been appointed associate administrator for property services for the 10 United Mine Workers Memorial hospitals in Kentucky, West Virginia, and Virginia, succeeding **Roy Hudenburg**, who has joined Community Health Association in Detroit. Mr. Hogan has been chief of the construction and maintenance branch of the U.S. Public Health Service for nearly 12 years. For several years prior to assuming his Public Health Service post, he was associated with Buffalo General Hospital, Buffalo, N.Y.



T. Joseph Hogan

Denison K. Bullens Jr. has been appointed superintendent of Wyoming County Community Hospital, Warsaw, N.Y. Mr. Bullens formerly was administrative assistant at Nassau Hospital, Mineola, N.Y. He is a graduate of the University of Chicago's course in hospital administration.



Denison K. Bullens Jr.

George G. Billington recently assumed the position of assistant administrator at Somerset Hospital, Somerville, N.J. Mr. Billington is a graduate of the course in hospital administration at Columbia University. For the last two years, he has been a research assistant on the faculty of the Columbia course and he will retain an official part-time connection with the faculty.

Dr. Robert C. Hunt has been named director of Hudson River State Hospital, Poughkeepsie, N.Y., succeeding the late **Dr. O. Arnold Kilpatrick**. Dr. Hunt formerly was director of Erie County community mental health services and an assistant commissioner of the state department of mental hygiene. Dr. Hunt has served more than 23 years in the department. As assistant commissioner for nearly five years, he headed the division of community mental health service following its inauguration in 1954. He is an associate clinical professor of psychiatry at the University of Buffalo School of Medicine. (Continued on Page 168)

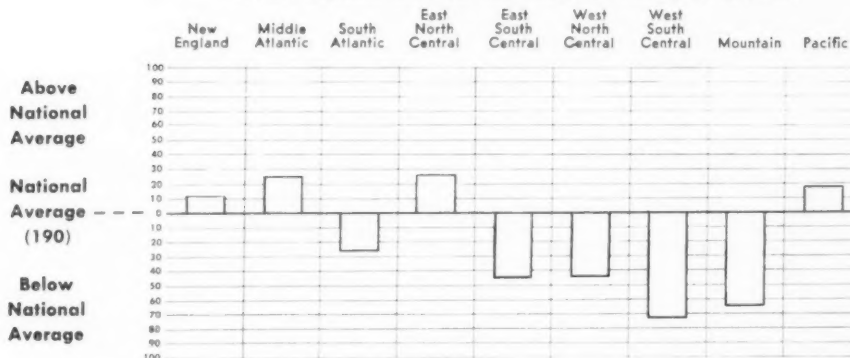
Regional Variations in Hospital Statistics

This study shows regional variations among long-term general and special hospitals as to size of hospital, total assets per bed, plant assets per bed, expenses per patient day, payroll per patient day, and the number of full-time personnel employed per 100 patients

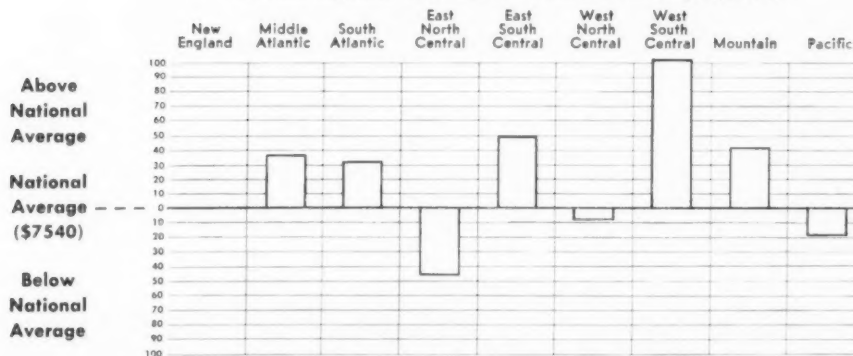
LOUIS BLOCK, Dr. P.H.

Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

SIZE OF HOSPITAL (Long-Term General and Special Hospitals)
Per Cent Regional Variation From National Average (190 Beds)

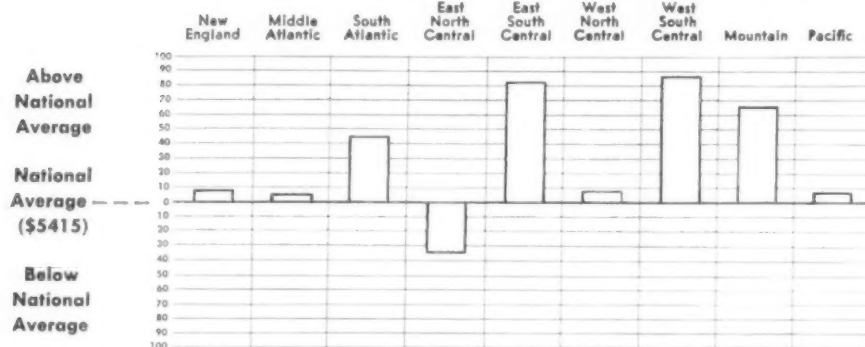


TOTAL ASSETS PER BED (Long-Term General and Special Hospitals)
Per Cent Regional Variation From National Average (\$7540)

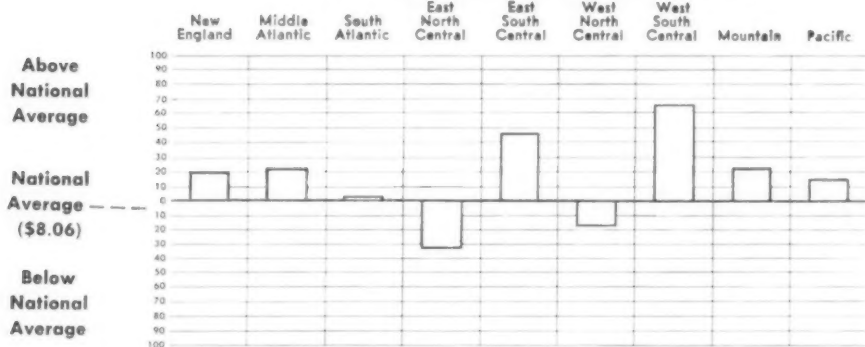


(Continued on Page 96)

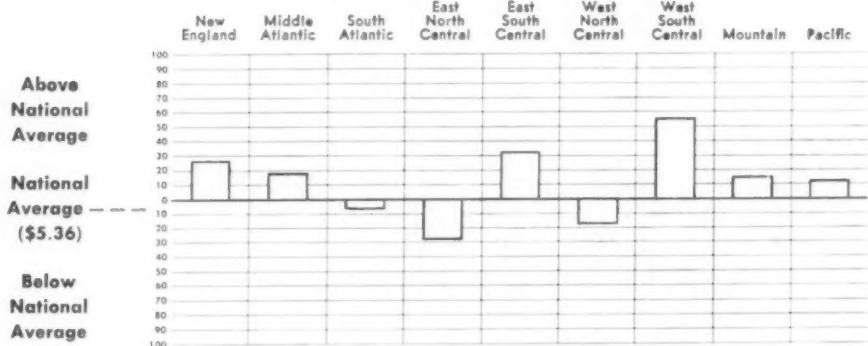
PLANT ASSETS PER BED (Long-Term General and Special Hospitals)
Per Cent Regional Variation From National Average (\$5415)



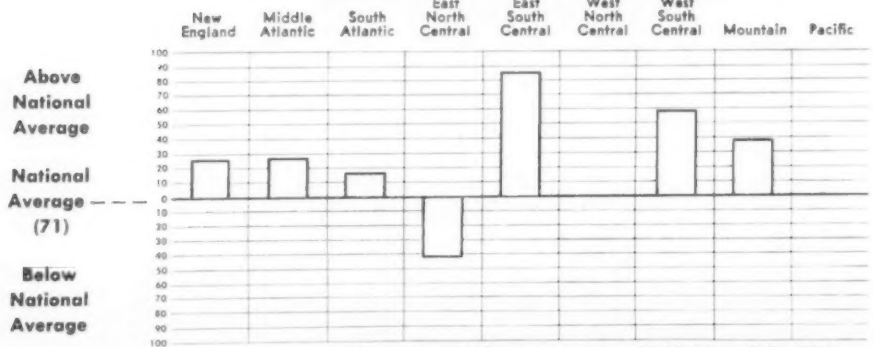
EXPENSES PER PATIENT DAY (Long-Term General and Special Hospitals)
Per Cent Variation From National Average (\$8.06)



PAYROLL PER PATIENT DAY (Long-Term General and Special Hospitals)
Per Cent Regional Variation From National Average (\$5.36)



FULL-TIME PERSONNEL PER 100 PATIENTS
(Long-Term General and Special Hospitals)
Per Cent Regional Variation From National Average (71)



Source: American Hospital Association, Administrator's Guide, 1988.

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MEDICINE AND PHARMACY

Conducted by Robert F. Brown, M.D.

Sterile Supply Fits Into the Pharmacy

The Clinical Center's program of preparing and dispensing sterile supplies under the supervision of the pharmacy has proved to be satisfactory to all departments involved

MILTON W. SKOLAUT and JANET L. FITZWATER, R.N.

PREPARATION and dispensing of sterile supplies and equipment is a highly specialized supply service. It will not fit into the general pattern of the supply department of the hospital owing to the specialization, but it can be fitted into and combined with the pharmacy department where the addition of the sterile supply service only requires expansion of facilities and an increased number of nonprofessional personnel.

The question is often raised "Can the pharmacy department successfully operate such a program?" The success of such a program, we believe, depends chiefly upon the cooperation between the nursing and pharmacy departments, in day-to-day operations, and the availability of the necessary phys-

ical facilities to make such an arrangement feasible.

The pharmacy-operated sterile supply program carried out at the Clinical Center, National Institutes of Health, has proved to be satisfactory and valuable. A description of some of the services will show that it is operated much the same as a pharmacy with certain adaptations to the particular situation.

Nonprofessional personnel, following a training period, is utilized in all areas of the service under adequate supervision.

The sterile supply service is divided into various units, namely: (1) needle and syringe, (2) cleanup, (3) dressings, (4) trays, (5) gloves and (6) surgery supplies.

The pharmacy department has pioneered in packaging dressings in single units for individual use. Bulk packaging has been discontinued. The ad-

vantages of individual packaging are economy in use of supplies and less possibility of contamination. In addition, the control system used for drug identification with minor adaptations has been extended to all sterile supplies. This control system identifies the material as to source, date of preparation and sterilization, and provides a coded recall number for future use. This places the full responsibility for sterility of these supplies on the pharmacy department and relieves all other hospital personnel of responsibility in this area. If at any time any material is questioned, only that particular lot number in question need be investigated. This is a timesaving and safe method.

Paper wrappers are used for wrapping all supplies for the patient care areas with the exception of supplies used in the operating rooms. Four-thickness muslin wrappers are used for



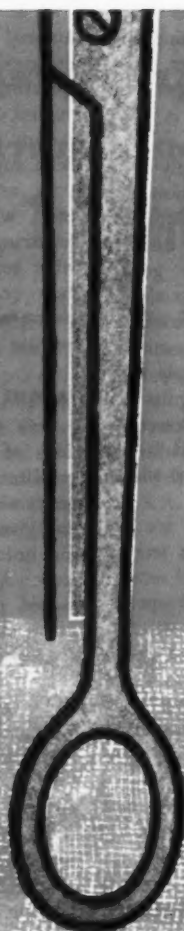
Recording potentiometers provide a permanent record of sterilizing temperature and the length of time required.



All of the used articles that are returned for processing are cleaned in this area prior to being packaged for reuse.

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THE PANCREAS
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operating room supplies. Paper wrappers are satisfactory for obtaining and maintaining sterility; however, they are not satisfactory for the operating rooms insofar as usability is concerned.

One unit in the sterile supply service is designated for preparation and storage of operating room supplies. Linen is sent from the laundry directly to this area. Packs, single goods, sponges, gloves and other materials are assembled and wrapped for sterilization. Sterilization is carried out in another area of the sterile supply service, following which the supplies are returned to the operating room section, stored in closed cabinets, and issued upon request, using the dumb-waiter delivery system.

Nonprofessional employees are assigned to the operating room section of sterile supply service. They receive their original training from an operating room nurse. Following their original training period they have recourse to the operating room nurse for direction and any necessary additional instruction created by changes in routines.

The operating room staff nurse no longer must fold linens, assemble packs, count and wrap sponges, test and package gloves, and do many other tasks that should be done by nonprofessional workers. Being relieved from actual performance of these duties and from constant supervision of nonprofessional workers performing these tasks, the professional nurse can devote her time to more complex and patient-related duties. The head nurse is no longer burdened with the constant checking and ordering of routine supplies and can utilize this time for study and procurement of unique devices and equipment.

It is necessary to keep only a minimal number of sterile packs, single goods, and similar items in the operating rooms, thus decreasing the amount of storage space necessary. The hazards created by storing sterile and clean supplies in the operating room work areas are eliminated. Folding linen, wrapping packs, cleaning and preparing catheters, drains, gloves and other supplies in an area other than the operating room contribute to providing a clean and safe environment for the patient.

TAUGHT PROPER TECHNICS

One of the most important functions of the sterile supply service is sterilization. Nonprofessional personnel is taught principles of sterilization and given instructions in proper loading, unloading and operation of sterilizers. A recording potentiometer attached to a thermocouple lead in a representative package placed in the appropriate location in the autoclave is used as a temperature recording control. This is an important part of the code and lot number system which was mentioned earlier. Since each sterilizer load has one lot number, regardless of contents, it is easy to recall all items if any package is suspected of being nonsterile.

The sterile supply service acts as a central loan area for certain patient care equipment which is not used continuously by the nursing units. This reduces the amount of equipment to be procured. When a unit has need for a specific piece of equipment it can be borrowed from the sterile supply service. Upon return, employees check the equipment, reclean all parts, make any necessary adjustments or repairs, and generally have the equip-

ment in perfect working order and ready for the next user. This alleviates a storage problem on the nursing units and relieves the professional nurse of the responsibility of servicing equipment.

The pharmacy department has established an effective method with the purchasing service for the procurement of drugs. This method has been extended to include clean and sterile supplies, instruments and equipment. This has eliminated the problem of specifications set by a purchasing service which all too frequently lowers specifications in order to purchase at a lower price. Since a close relationship already exists between nursing and pharmacy on pharmaceuticals, favorable or unfavorable comments and evaluation concerning supplies are readily communicated.

From the administrative point of view the responsibility for the greater portion of supplies and equipment for the patient, with the exception of food and laundry, is centralized in one department. This is a more efficient operation since responsibility or blame cannot be shifted between departments, but can be pin-pointed.

The pharmacy department has established a method of interviewing and screening sales representatives for drugs and chemicals and this method can be used for the screening of additional representatives for supplies, instruments and equipment. This centralizes patient care procurement so that items can be screened or tested centrally before being purchased.

The responsibility of the pharmacy committee is extended to include supplies and equipment. By having nursing, medical and pharmaceutical representation, the committee can readily resolve problems of both sterile supplies and pharmaceuticals.

Pharmacists are members of the nursing practice committee. This committee provides the basis for close cooperation and effective communication between the nursing and pharmacy departments.

Now the question asked earlier: "Can pharmacy operate the sterile supply service?" The answer developed at the Clinical Center, National Institutes of Health, is affirmative, but only because of close and complete cooperation between all departments concerned. Central administration was willing to try this departure from the routine, and its conclusion is in agreement with our statement.



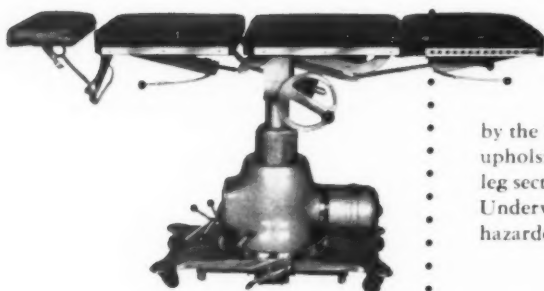
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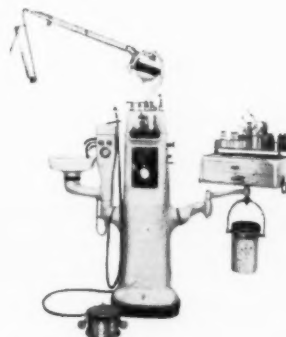
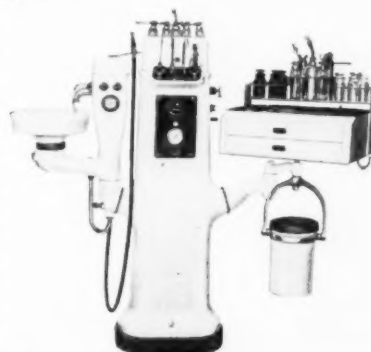


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The Modern Hospital Nursing Round Table

(Continued From Page 76)

minimal care unit and then gone to another unit, and when they reached the regular unit they say: "When can I go back to the minimal care unit? Everything is so much more relaxed, we see much more of the nurses, the patients are not as ill, and we enjoy their companionship."

Voice: Do you have trouble getting patients off the maximal care unit? Now the doctors at our hospital are more concerned with their own patients than they are with the average, and they'll wangle extra services for their own patients if they can. How do you get the patients off of the maximal care unit without disturbing the doctor and the patient?

Miss Sleeper: Our situation takes care of itself. There are 20 beds on the medical unit, 10 of which belong to one medical teaching service, and 10 to a second, so that if the doctors want to get more patients in, they have to move patients out. They set their own limits.

If we had a maximal care unit on the private side, or the semiprivate side, that would be very different, and the doctors would wish to leave them there, and I think we have to have very firm policies which would give nursing a voice in the evaluation of the patient's readiness to move, along with the medical voice, just as we do today in the assignment of private duty nurses. The nursing supervisor has a strong voice in deciding when the private duty nurse will be taken from one patient to be assigned to another one who needs more care.

Doctor: I'm a psychiatrist at a 5000 bed state mental hospital. But my interest is in the practice of medicine as well as psychiatry, and I get an impression which alarms me, that all we've been talking about here has to do with mechanical, physical and technical procedures. How much time does the nursing personnel, in all categories, spend, and how much should be spent, with the emotional needs of the patients and the patients' families?

Mr. Olsen: That question can always be thrown at the administration or the nursing department when they're trying to live with a difficult situation. Obviously, the one thing we have to think about all the time is the patient's needs. But we're in a situation where we know there's a

shortage of medical personnel. We're trying to find out how we can give the best care to the people in our hospitals with what we've got.

Miss Sleeper: This is where our inservice education programs come in. We do not have all our nurses prepared in mental health and psychiatry. But if we have a good inservice education program, one of the things which every worker in nursing—aide, practical nurse, nurse—can have help with is an understanding of the patient's emotional needs, and insight into the fact that those may be the most important needs.

Voice: Who's with the patient most of the time? Who's giving him information and giving him supportive care? We're finding that it's the least skilled members of our staff. There's something wrong with job assignments that keep our professional nurses away from the patient. The professional nurses are involved in patient-centered activities, but not at the patient's bedside.

A nurse's aide said recently, "We give personal care to the patient—baths, back rubs, and things that take time—so we get to know him. More than that, we make him feel better, whereas the nurses do nothing but stick patients with needles and other things that hurt. When we go back to see the patients they're glad to see us, because we've made them feel better, but the R.N. who's been hurting them doesn't want to go back."

Nurse: Do you think the transfer of patients to these various classifications such as a maximum care unit and a minimal care unit is traumatic? Or do you think he can adjust to that many new situations?

Doctor: His attitude toward the physical facilities certainly has a great deal to do with the patient. At one mental hospital in Virginia, unfortunately, for example, they named a geriatrics building after a lady named Seese. So those patients went to the "cease" building. You can understand how traumatizing it was!

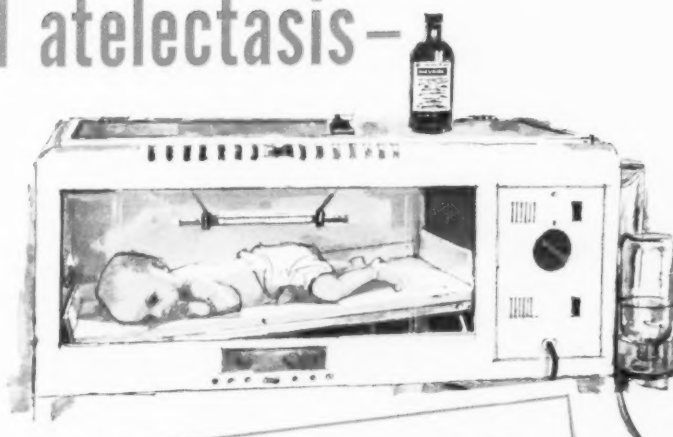
Mr. Sloan: Mr. Friesen, someone would like to have you explain further your proposal about a central service area. How does it function?

Mr. Friesen: Instead of developing a linen room as such, a flower room as such, and a diet kitchen as such, we would like to have what we refer to as a service core. We have no linen room as such. We don't believe in putting things from shelves

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CASE REPORT

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The infant was placed in an optimal oxygen concentration in an incubator. Although color and respiration somewhat improved, he remained lethargic. His condition became worse the following day, and respirations were rapid and shallow.

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- pneumoconiosis • smoke, kerosene poisoning
- poliomyelitis (respiratory complications)
- routine oxygen therapy • tracheotomy
- prevention of postoperative pulmonary complications

*Smessaert, Andre; Collins, V. J.; and Kracum, V. D.: *New York Jour. Med.*, 55:1587, June 1, 1955.

Alevaire, trademark reg. U.S. Pat. Off.

to a cart, and then from a cart to shelves. We merely have shelves on wheels, whether it's for sterile supplies, or general supplies, or intravenous solutions. Everything must be pre-packaged. The nurse can go into this one area, which we refer to as a service core, and get anything from orange juice to an intravenous tray. We have gone a step further since that was developed, so that in the event she runs short of the predetermined complement, all she has to do is press a button and speak to the dispatcher. Whatever she needs can be placed by him on a belt conveyor and ejected

automatically in any sequence on any floor. We've got to put everything on the production line. Why should we be afraid of things that are done in industry? They're doing it efficiently. Let us put everything on the production line that the nurse or doctor may need. But let's make sure we don't put the patient on the production line.

Mr. Sloan: If student nurses are to see the patient from admission through discharge, how is this possible when patients are moved from one department to another as their care progresses or changes?

Miss Sleeper: Continuity of care

is very important, and one of the ways that's available for maintaining continuity of care is through the development of a good nursing care plan. This is developed on the unit where the patient is first admitted, and that plan follows the patient to the other units. Communication between the staffs of the two units also is helpful.

Mr. Sloan: In establishing delivery services of supplies to the patient areas, does nursing relinquish a staff position from the floor to the department delivering supplies?

Miss Sleeper: Sometimes if we give our functions to another department, it is possible to transfer some positions to the other department. But if it's nursing personnel that can give nursing care, then the nursing service ought to try very hard not to let that happen. You want to hold on to the nurses!

Mr. Friesen: It becomes the responsibility of the stores clerk to see that supplies are available. There should be no delivering done of any type under any circumstances by nurses.

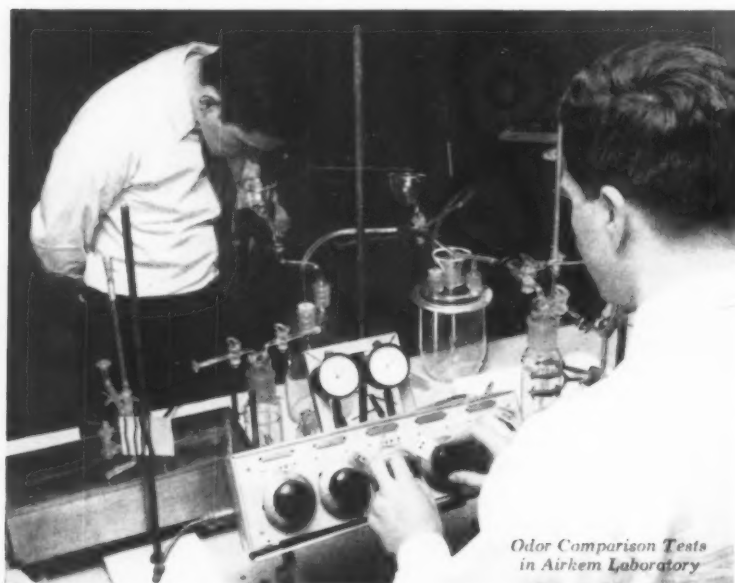
Mr. Sloan: When the patient is transferred to the minimal care unit, how are his clothes handled? Does he object to changing location? Are prices lower in these units?

Miss Pratt: His clothes are handled the same as in any unit transfer in our hospital; the clothes go with the patient. In each patient's room, each patient has his own locker, and his clothing is put in the locker, beside his bed. There's no difference in the charge to the patient.

Does the patient like it? We feel that most patients do. People who have been in a regular unit and are admitted to a minimal care unit say that they like this much better; there are not as many sick people, and they see more of the nurses.

Mr. Sloan: Is there a plan in smaller hospitals for someone in the hospital administration department to be on duty throughout the 24 hours? We find the night supervisor being asked to assume these responsibilities.

Voice: That is one of the biggest problems we have. Nursing service is on duty 24 hours a day; the other departments are not. So we find the nursing service supervisor, who should be around with the young staff members who are functioning as head nurses on the afternoon and night shifts, is still running errands around the hospital. #



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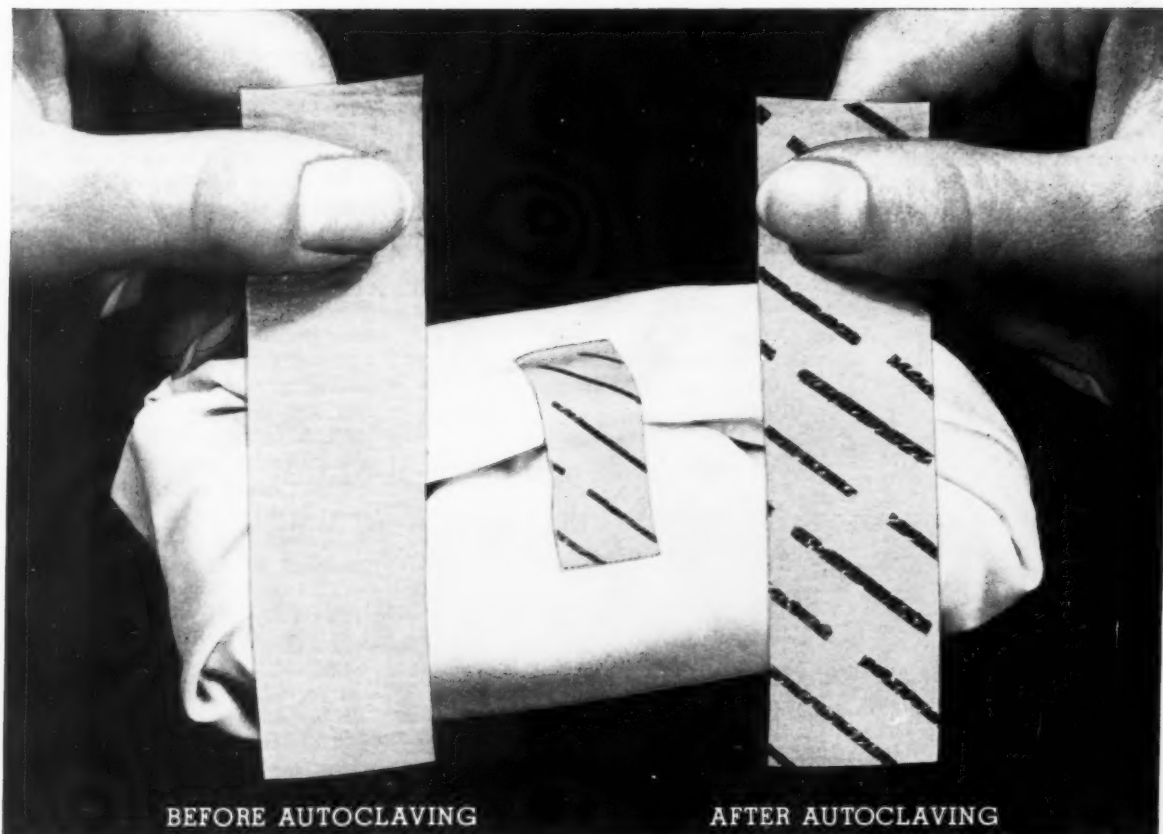
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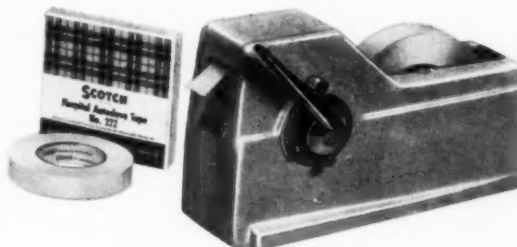
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Medicine's New General Manager

(Continued From Page 54)

medical practice. I think that the examples of union and other third-party plans are attempts to approach the solution of medical care problems in a little different way. I think we're too close to these experiments yet to see how they're going to develop over a period of time. We need to give them the test of time to see whether or not they are sound. Perhaps some other new mechanisms will arise. Let's just

let them operate and see how they do. If they can do a better job in a particular situation, let them do it! I question whether or not they will be able to survive over a period of time, but let them try. I think they are approaching the solution of the problem from an economic standpoint primarily, and are perfectly justified in doing so. Perhaps a lay group may be smart enough to operate a given facility more wisely in a particular instance than anyone else.

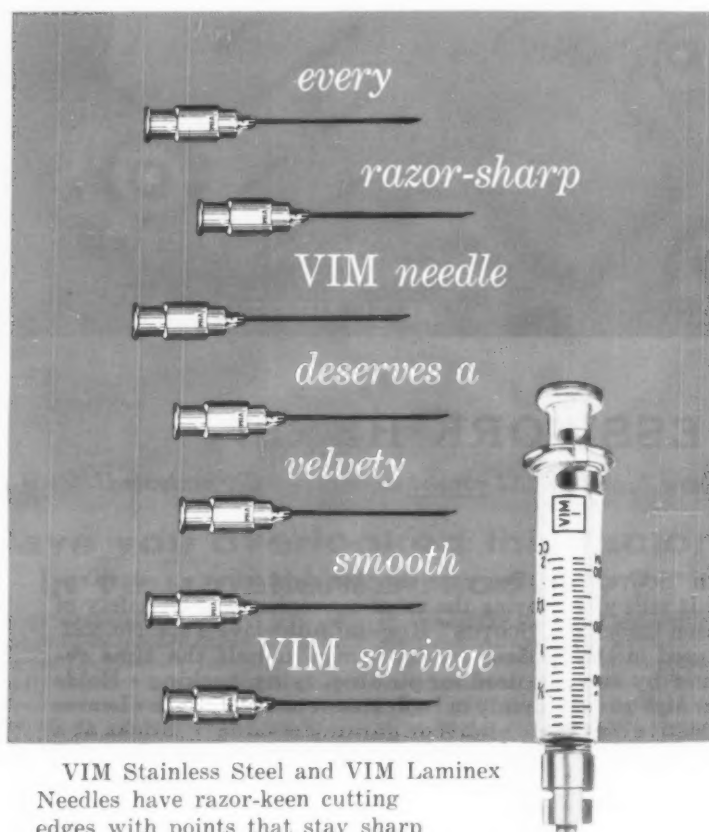
Fundamentally, it's a question of motivation. Why are they in the busi-

ness? Are they in it to make an economic experiment, or are they in it for the care of the sick? Philosophically, the care of the sick individual—to give him the best possible medical care at a reasonable cost—is a laudable desire whether it's done by professional people or lay people. It's difficult in such a technical field as medicine to see how lay people can be motivated over a period of time to carry on an institution that will survive. But let them try, and let's see if they can do a good job, or a better job. I have my doubts, but time will tell. I cannot see how any plan can long survive if there is impairment of the patient-physician relationship.

Blue Cross, Blue Shield and Insurance. In the financing of medical care, the main thing is to keep in mind that you must not impair the quality of medical care. We don't want to be economically silly, but we must not hinder the free application of good talent and good facilities to the needs that exist. I believe necessary financing can be done best by the pooling of resources, either by Blue Cross-Blue Shield or through the commercial insurance companies. As in the operation of lay-sponsored groups, we need in the American economy every effort to solve this problem on a free and open basis, as long as we keep in mind that we want to take care of sick people and give them good quality medical care and good facilities on a sound economic basis.

We have the mechanism in Blue Shield and Blue Cross, and also in the commercial carriers of this country, to finance every reasonable medical and hospital need. The people are budgeting for it. They are willing to buy insurance in this field and pay for it.

Expansion in this particular field has been phenomenal. When you compare the development of health insurance to the development of fire insurance or life insurance, you find that the expansion in the health field has been very rapid. I think we need to have patience with the problem and give the seriously interested parties time to examine the facts and to advance on a sound basis. The American people are being well cared for in the meantime. Statistically, everybody's getting along pretty well. There may be individual cases of hardship. We still have problems and I don't mean to tell you we don't have them. But we shouldn't rush in quickly and say, "It can't be done." A few years ago, insurance



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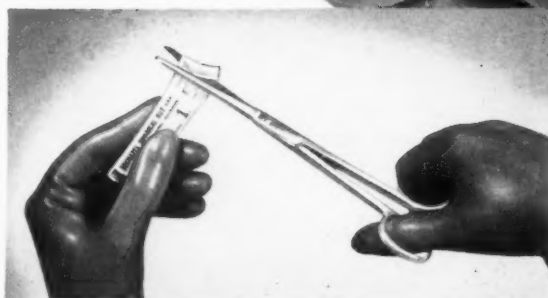
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companies felt that you couldn't insure illness, and now they've changed their concepts. But we must not expect them to do it on any basis that isn't sound, for fear that we will actually slip back and create financial disasters.

Old Age and Mental Illness. Let's admit that perhaps we'll always have some uninsurable groups in society. I think, for example, that a certain number of mentally ill patients are irretrievably lost from the standpoint of being economically productive, so we cannot consider them to be insurable, and they become an obligation of so-

ciety. There may be some other groups, but, in general, insurance should be applied wherever possible. We should give consideration to the application of insurance in our productive years to help tide over some of the years that we now consider beyond the range of insurance. I feel these problems are yet to be solved by ingenuity, and by sound economics and good philosophy. We must not jump in and say that this is a government responsibility before we have given years of experiment and trial to solving the problem. If you let the politicians and bureaucrats

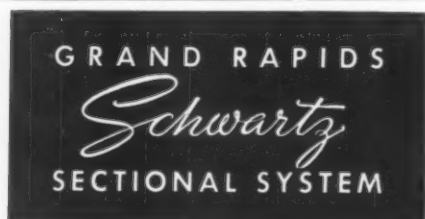
begin to take a hand, you immediately make it a permanent, chronic government problem, a burden on the taxpayer. I contend that we have resources in the insurance field and in the medical field to work out this problem.

Medical Care of the Indigent. The indigent or needy individual needs to be evaluated at the local level. I know about the needs of my patients—those who are marginal individuals economically, who are actually uninsurable and in need of help, but need has to be measured locally. There's still a place in American life for charity to begin at home. If we look to government to take care of the indigent and grandma and grandpa, just because they are a little feeble, then I think we've lost some of the fine qualities of American life.

I don't think there's any need to provide hospitalization for social security beneficiaries through an amendment to the Social Security Act at this time. I think it would represent a moral deterioration, even if it were economically the prudent thing to do, and I don't look upon it as economically prudent. I don't think the government has the finances for doing it. I don't think it has the facilities for doing it. Why not leave those dollars in the hands of Mr. and Mrs. John Doe either at the state or local levels, where need can be more accurately determined, and let those people take care of themselves? That's the sound way to do it.

Medical Public Relations. In general, the press is good to the medical profession and hospitals. I saw recently from the public relations department of the American Medical Association an evaluation of medical articles published by mass circulation magazines during a 12-month period. Some 93 per cent of the articles were favorable to American medicine, while 7 per cent were derogatory in some degree. That's a pretty good batting average, and I think that medicine is occasionally subject to criticism. Naturally, as complicated as it is with as many relationships as it has in society, there will be some groups which feel, or some individuals who feel, that an injustice has been done, and they are entitled to criticize. I think it's good for medicine and good for the public to have those criticisms.

In general, I think we are doing a commendable job in the care of the American people. I think they know it and appreciate it.



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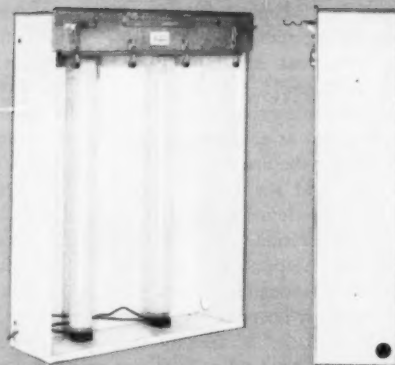


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How Administrative Dietitians Get That Way

Although this article is addressed primarily to the young dietitian who is still deciding whether she wants to stay in the hospital field and how best to go about reaching the top, it should provide food for reflection among older dietitians and their administrators as well

DOROTHEA BARTLETT

AT A recent convention one of the sessions on food service management had a panel composed of representatives of some of the types of food service management found in the hospital field today. Among them were the steward-manager, the commercial managerial program, and the dietitian-manager. I represented the last: the dietitian in full charge of the hospital food service program.

WHAT DOES SHE DO?

What is the department head dietitian and what are her responsibilities? She is a qualified dietitian, *i.e.* she has as her background four years of college with a bachelor's degree in institution management and/or nutrition plus one year in an approved internship program.

She has had some experience in food service operations as an assistant dietitian either in the therapeutic or administrative field, and she has developed through this experience a major interest in administration. She is employed by the hospital administrator and is directly responsible to him. She is one of the many hospital department heads and, as such, is directly concerned with the hospital-patient relationship as a whole, but more specifically as this relationship is affected by the food service. All problems related to this phase are directed by the administrator to her, and she is directly responsible, with no "third party" concerned. Her loyalty is to her em-

ployer—the hospital—and therefore her efforts are directly for the benefit of the hospital and its purpose—better care for the patient.

What are the administrative dietitian's responsibilities? (Remember, the larger the hospital, the more of these responsibilities are delegated to assistants. However, she must have a skillful working knowledge of them all, otherwise she cannot delegate, supervise and advise effectively.)

Based on my own experience, I would list the responsibilities of the head dietitian in a 300 bed hospital as follows:

1. With approval of the administrator, establish the standards of food service to patients and personnel and establish department policies.
2. Present, and obtain approval for, the annual budget for department activities necessary to maintain the established standards and policies.
3. Prepare or supervise preparation of menus for food served to patients and personnel, keeping uppermost in mind nutritional needs of all. This must include patients whose illness requires modifications in diet. (Usually an assistant therapeutic dietitian gives personal attention to these patients and plans the modified diets around a master menu.)
4. Purchase or requisition foods needed to carry out the menu successfully. This involves checking on quality and grades required to maintain the original standards established.
5. Purchase or requisition food service equipment and utensils when

needed and be responsible for their proper maintenance.

6. Employ, orient and train employees for their duties in food service.

7. Establish and maintain adequate records of food, equipment, personnel and the costs to meet the requirements of the administrator. These are necessary, too, for the dietitian, so that she may be satisfied that costs are constantly being studied and controlled. (Usually weekly or monthly financial statements of the department activities are required. However, if they are not, the dietitian should still prepare them as a guide for herself.)

8. Maintain an open-minded cooperative interest in interdepartmental problems and activities.

9. Obtain the respect of all for the dietary department; and for herself, the respect of her associates and employees.

HOW DOES SHE GET THERE?

The next question is how a dietitian becomes an administrative leader. This has partially been answered in the explanation of a "qualified" dietitian. The education, specialized training and experience prepare one for these responsibilities. All except the last two are technical skills, learned or observed in college and put into practice during her internship and experiences.

The experience I refer to is perhaps the most important factor in the making of a successful administrative leader. My advice to the young dietitian just "stepping out into the world" after her internship is to plan each

Miss Bartlett is chief dietitian, Mary Hitchcock Memorial Hospital, Hanover, N.H.

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move thoughtfully after deciding what is to be her professional goal. If she is not completely confident of herself or her abilities, or even of her goal, she would do well to take a position as an assistant dietitian in a fairly large, well organized dietary department. If she feels surer of her therapeutic abilities, she may take a position as a therapeutic, or perhaps even a teaching, dietitian. If she already knows administration offers more of interest to her, she may take an administrative position in charge of a small unit of the department. Whatever her choice, in a large department she not only gets good experience but she has the feeling of good backing or support, so essential in establishing confidence when one first really puts into full practice the theories learned over a long period of time. After one year, she should have a clearer picture of what her goal will be. As a team member with the other types of dietitians she should not only have developed confidence in the work she is doing, but she should have learned to evaluate the various dietetic positions and the responsibilities attached to each.

TAKE MORE RESPONSIBILITY

If she decides administration is her field, her next move (if she has been doing therapeutics) is to an administrative position or perhaps a position that combines the two types of activities. If she has been doing administrative work, her move should be either to the supervision of a larger unit in the department or to another hospital or organization where she will have increased administrative responsibilities. It is this move that I consider of great importance. It is also the move that too many potential department heads fail to make, or, if they make it, they make the wrong move.

I believe administrative experience is improved by seeking employment in the smaller hospitals. In the smaller hospitals every dietitian, regardless of her specific assignment, is more fully exposed to the responsibilities of the department head. Where there are only two, three or possibly four dietitians on a staff, each one is more aware of the intradepartmental activities. In the small staff organization each one may, during vacation periods or in emergency situations, have to assume additional duties, and the assistant dietitian who finds herself relieving for the department head has a most valuable opportunity. Some-

times this comes unexpectedly, and if she has selected administration as her eventual goal, in the small department she will have the chance to prove herself far sooner than if she were with a larger staff of six, eight or more dietitians.

All too frequently young dietitians stay in large departments too long. I have heard it said that dietitians tend to "hive together like bees." If this is so, it appears that one of two conditions is true: Either they are antisocial and thus always feel a need to be near those with whom they have a common interest, or they are afraid! Yes, afraid to go into areas where they will not find as many others with a common understanding and background on whom to lean. They are afraid to assert themselves as professional people who can make valuable contributions to the welfare of a community or organization. I hope neither of these suppositions is true. Rather, I would like to think that the young dietitian likes the activity and glamour of the metropolitan areas and association with well organized modernly equipped dietary departments. If this is so, let me remind the young dietitian that there is glamour and activity almost everywhere—if you look for it and contribute to it. Also, surprisingly enough, there are many modern, well organized dietary departments in small hospitals throughout the country. There would be many more if dietitians would go out and help plan, organize and operate them.

The moves following the one where more administrative responsibilities are obtained depend on the individual, her abilities, and her goal. She may move up in the small organization—even to the top as department head. This may satisfy her goal or she may return after a time to a larger hospital as administrative assistant to the department head or she may become the head in the larger organization. Whatever her ultimate goal, I feel that if she is ambitious, she will reach it more quickly through the route of the small hospital or department. I feel sure there are too many potentially good leaders submerged in the crowds of the larger organizations. They seldom have the opportunity to prove their potentialities to others as well as to themselves.

In outlining the way to become an administrative department head, perhaps I have appeared to overemphasize experience. It is impossible to do this,

in my estimation. It is my belief that the encroachment by business and industry into the field of hospital dietetics is the result of two factors, namely: (1) the eagerness of the young dietitian to undertake department responsibilities for which she is not experienced. She has had her education and training, but she has not taken the time to learn the "way up." She wants to start at the top. (2) The hospital administrator, in desperate need for a dietitian, all too hastily employs a young dietitian with no previous experience. Both situations often end in failure, so often, in fact, that the dietetic profession as a whole has been accused that its members do not know the food business. The old maxim "experience is the best teacher" should always be written with emphasis.

EXECUTIVE ABILITY IS A MUST

Finally, before leaving the topic of how to become the administrative head of a hospital dietary department we should consider two factors: The first is executive ability. This is a definite requisite. Usually, it is an ability that one is not aware of until the need to use it arises. Again, this need most frequently occurs during the time experience is obtained. Experience tends definitely to develop executive ability. If one does not have this type of ability, it can be acquired but this is a long procedure and frequently unsuccessful.

General interest, poise, character and personality are other requisites. To accomplish one's responsibilities successfully one must be patient, tolerant, fair, sympathetic and cooperative by nature. Also, one must enjoy working with people and understand their problems. Above all, one must enjoy good health obviously based on good nutrition practices which should ultimately lead to a well balanced, well rounded personality.

At this point, some may feel the goal of department head is too far away. It really is not too long, an average of five years perhaps, often less, depending upon the individual. Some young dietitians are topnotch executives the day they graduate from an internship. Best of all, the dietetic profession lends itself admirably to the profession of homemaking. The foregoing program can usually be interrupted at any stage and returned to where one left off after a few years if one retains professional ties.

The last question to be answered

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is why the qualified dietitian should be placed in charge of the hospital dietary department. First of all, she is trained for it. She has behind her a solid education in the field of liberal arts and sciences with specialized emphasis on the latter. She has learned quantity food purchasing and preparation; she has learned food cost control, budgeting and food accounting. She has studied nutrition, diet and disease, equipment, food service organization, and management. She has a sound background for these responsibilities in her studies of physiology, chemistry,

sociology and psychology. She has put her education into practice during a year of concentrated, practical, well supervised and planned work as a dietetic intern. Finally, she has developed her abilities by experience in one or more types of positions. If she has proved her abilities and has the personality, who else is better prepared to set up and operate a food service organization where the prime responsibility is to know, understand and serve the food needs of sick people? She has the knowledge to act intelligently as a team worker with the doctor; she

is aware of the importance to the morale of doctors, nurses, interns and employes of good food attractively served and, as a member of the hospital staff, she has a deep sense of loyalty and pride in having her department efficiently operating for the welfare of the patient.

WHY BE A HOSPITAL DIETITIAN?

Why should any dietitian with executive ability want to undertake such a program? Because she knows she is prepared for it, and because she desires to be associated with an organization of service. She knows there is no greater reward than the knowledge that she is directly responsible for improving and maintaining a happy hospital-patient relationship.

The gratifications of being associated with such an organization are difficult to put into words. They are concerned with both a feeling of "belonging" and a feeling of service. Problems? Criticism? Yes, there are always those where one works with people, especially when food is concerned. But in this type of dietary department organization, the head dietitian knows that the problems and criticism, if justified, are of her own doing: either owing to the fault of policies she established or owing to poor performance on the part of herself or her employes. (Even this latter situation is basically her fault through improper direction or supervision.) Therefore she has a strong urge to correct the situation, or, better still, she has the incentive to foresee situations and thus prevent the problems from becoming real. This is just plain human nature. Yet the same person would be likely to take far less interest if she were placed in the hospital under the direction of an outside party. Here her first loyalties must be to her "boss," the third party, be it a concessionaire or an industrial foods service organization. Hospital problems would naturally be of secondary concern.

Does the hospital want disinterested staff members? I hardly think so. Do dietitians want to be "outsiders" within the hospital in which they work? I am sure they do not. And they need not be if they will assert themselves, spread out into the hospital food service field, and prove to be efficient, businesslike operators. This, plus their natural faculty for human understanding, sympathy and a love for service, should make a combination that no outside commercial competition can ever meet.



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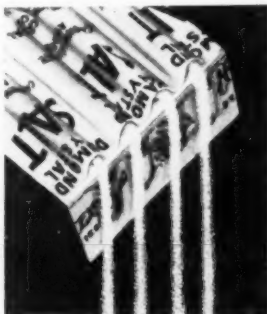
Each packet contains a generous serving of either pure Diamond Crystal salt; spicy ground black pepper; or fine granulated sugar. When the patient finishes his meal, the packets are thrown away.

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The welfare of cling peaches is guarded carefully. Only certain varieties of peaches are chosen for canning, because they consistently offer firmness, shapeliness, texture, flavor and eye appeal.

To meet consumer and institutional requirements, peaches are packed in various size cans. Hospitals, small or large, find exactly the size container which is suitable for their use.

Canned cling peaches are carefully graded. There should be no doubt in the mind of the institutional buyer as to exactly what he is getting for the specific requirements of his institution:

Range of Sizes, Content and Number of Servings in Containers

Container	Approximate Net Weight	Approximate Content	Approximate Servings
Buffer	8 oz.	1 cup	2
No. 1 tall	1 lb.	2 cups	4
No. 303	1 lb.	2 cups	4
No. 2	1 lb. 4 oz. (approx.)	2½ cups	4 to 5
No. 2½ can or glass jar	1 lb. 13 oz. (approx.)	3½ cups	6 to 7
No. 10	6 lbs. 12 oz.	12 cups	25

Fancy. The top grade or superlative quality fruit; perfect shape, ripe, tender, rich color, no blemishes; packed in extra heavy sirup.

Choice. Fine quality fruit reasonably free from defects, uniform in shape and color; packed in heavy sirup.

Standard. Medium grade fruit; ripe, good color. May vary some in texture. Fairly free from defects and fairly uniform in size; packed in light sirup.

Pie and Solid Pack Pie. Wholesome fruit packed for the bakery trade.

There are several types of sirups in which canned cling peaches are packed. Again, choice must be guided by institutional needs: (1) extra heavy sirup or extra heavy peach juice sirup;

(2) heavy sirup or heavy peach juice sirup; (3) light sirup or light peach juice sirup; (4) slightly sweetened water or slightly sweetened peach juice; (5) water alone; (6) peach juice alone.

Because rigid quality control assures good tasting as well as dependably firm and shapely fruit, the uses of cling peaches as a recipe ingredient are manifold. Peaches can begin the day, used for breakfast, and end it, with late evening nourishment such as peach milk shakes or milk punch.

Peach crowned cereals; sauces, some delicately spiced, for waffles and hot cakes, and butter and honey brushed broiled peach halves are especially good breakfast possibilities.



Old Style Peach Cobbler

Serves 25

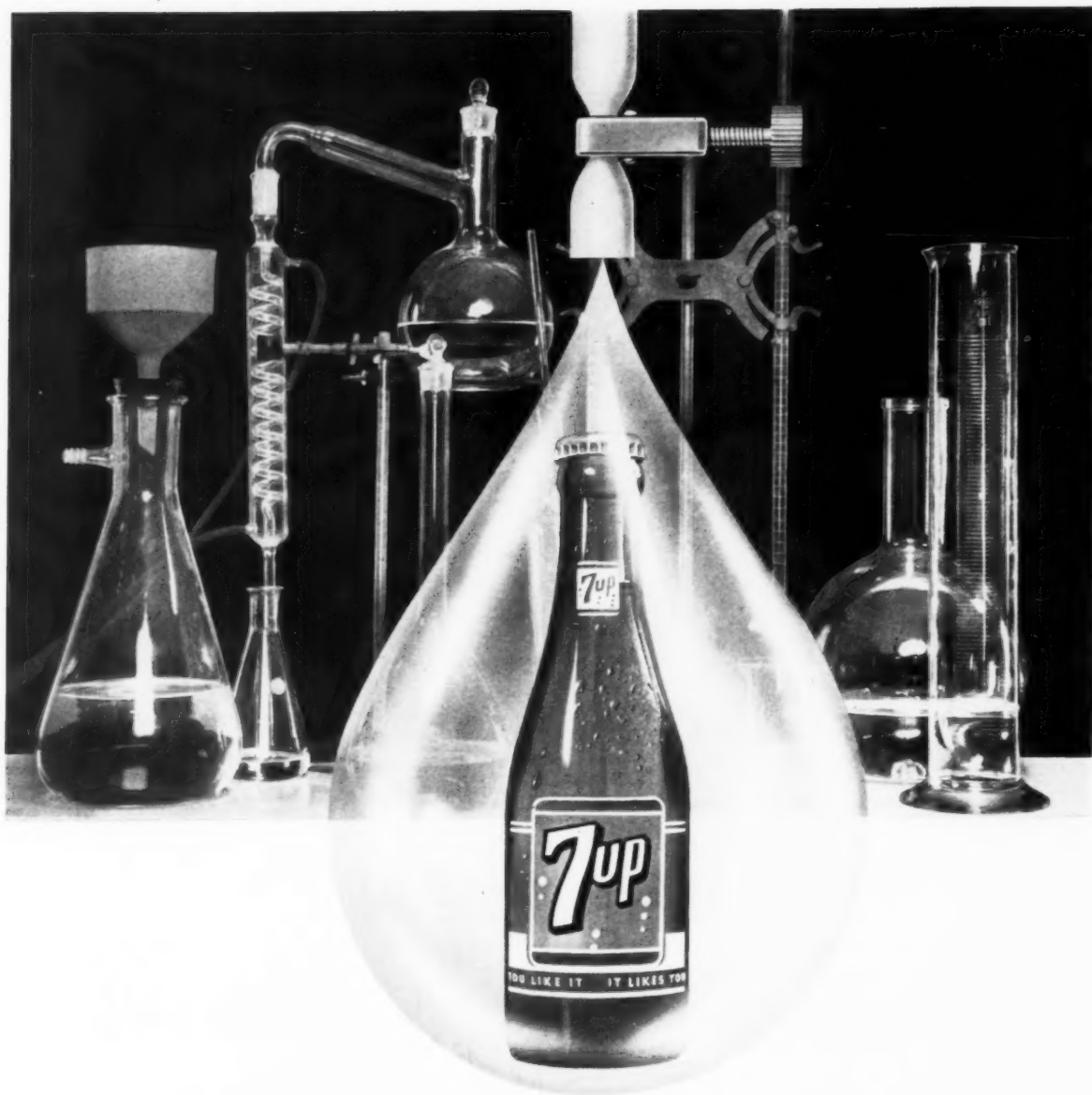
- 1 No. 10 can cling peach slices ½ cup all-purpose flour
1 cup brown sugar (packed) ½ teaspoon salt

Place drained peaches in bottom of four 1 quart casseroles or one baking pan 10 by 18 inches, approximately. Combine peach sirup, brown sugar, flour and salt, and pour over peaches. Set casseroles or pan in hot oven, 425°F., for 10 minutes.

Dough

- 4 cups sifted all-purpose flour ½ teaspoon baking soda
2 teaspoons salt ½ cup shortening
¼ cup sugar 1½ cups sour cream
3 tablespoons baking powder ½ cup milk

Sift together flour, salt, sugar, baking powder and soda. Cut in shortening. Stir in cream and milk and mix lightly to make soft dough. Place by spoonfuls on top of hot peaches. Bake 30 to 35 minutes until well browned. Serve warm with sweet or sour cream.



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Nothing does it like Seven-Up!

Menus for October 1957

By Virginia Kornya

Dietitian
Franklin Hospital
Benton, Ill.

1 Grapefruit Sections Bacon Strips • South American Pot Roast, Gravy Mashed Potatoes Garden Salad With Vinegar and Oil Cherry Cobbler • Chicken Rice Soup Macaroni and Cheese au Gratin Pickled Beets Vanilla Pudding With Peach Flower	2 Apricot Nectar Soft Cooked Egg • Grilled Liver With Onion and Bacon Curls Escalloped Potatoes French Green Beans Molded Pear Half in Raspberry Gelatin Pineapple Upside-down Cake • Hearty Vegetable Soup Spiced Ham and Cheese With Toast Points Warm Berry Cobbler With Cream	3 Tomato Juice Waffles, Sirup • Chicken Pot Pie in Individual Ramekins Buttered Peas and Carrots Waldorf Salad Ice Cream Chocolate Chip Cookies • Citrus Juice Cocktail Creamed Chipped Beef on Toast Asparagus Peach Half With Cottage Cheese on Lettuce Gelatin Jewels	4 Pineapple Juice Poached Egg • Fried Fillet of Catfish, Tartare Sauce Oven Browned Potato Brussels Sprouts Molded Perfection Salad Lemon Meringue Pie • Cream of Tomato Soup Tuna Salad Potato Chips Tomato Wedges Blue Plums	5 Blended Juice Scrambled Eggs, Ham • Grilled Hamburgers Potato Salad Buttered Wax Beans Sliced Tomato, Lettuce Wedge Applesauce Cake With Rum Flavored Hard Sauce • Chicken Noodle Soup Eggs à la Goldenrod on Toast Harvard Beets Molded Fruit Salad Sherbet	6 Grapefruit Half French Toast, Sirup • Virginia Baked Ham, Raisin Sauce Candied Yams Broccoli, Lemon Butter Garden Slaw, Sour Cream Dressing Angel Food Cake, Cherry Nougat Ice Cream • Beef Vegetable Soup, Toast Points Pear and Pineapple Rings With Cottage Cheese Floating Island
7 Grape Juice Soft Cooked Egg • Boiled Corned Beef Brisket Buttered Potato Cabbage Wedge Whole Carrots Bing Cherry Salad Boysenberry Pie • Bouillon Cup Creamed Ham and Mushrooms, Dutch Rusk Spiced Peaches Hot Cabbage Slaw Lemon Meringue Pudding, Whipped Cream	8 Peach Nectar Bacon Curls • Roast Leg of Veal Spiced Peas Whipped Potatoes Buttered Green Peas Carrot-Raisin Salad Coconut Cup Custard • Cream of Potato Soup Escalloped Eggs and Asparagus Peach-Nut Cream Cheese Balls on Lettuce Marble Pie, Whipped Cream, Chocolate	9 Tomato Juice Scrambled Eggs • Beef Stroganoff Buttered Noodles Buttered Asparagus Orange, Grapefruit Sections in Gelatin Apple Pie, Streussel Topping • Oxtail Soup Fruit Salad With Celery Seed Dressing Cottage Cheese Cinnamon Toast Hot Fudge Sundae	10 Apple Juice Poached Egg • Grilled Pork Chop Spiced Crabapple Snowflake Potatoes Buttered Peas, Carrots Sliced Tomato, Lettuce Chilled Melon Balls With Lime Sherbet • Noodle Soup Veal Turnover With Vegetables Garden Glow Salad Cherry Filled Cookies	11 Citrus Fruit Sections Soft Cooked Egg • French Fried Shrimp, Cocktail Sauce Potato Salad Slaw Tomato Wedges Lemon Chiffon Pie • Tuna, Noodle and Vegetable Casserole Molded Fruit Salad on Endive Lemon Drop Sherbet	12 Banana Sweet Roll • Roast Top Round of Beef With Mushroom Gravy Whipped Potato Brussels Sprouts Tomato Aspic Ring With Cottage Cheese on Endive Banana Nut Cake With White Butter Frosting • Spaghetti Italiane With Tiny Meat Balls Tossed Green Salad Poppy Seed Rolls Pineapple Tidbits
13 Fresh Grapes Link Sausage • Fried Chicken Whole Kernel Corn With Pimiento Buttered Asparagus Sunshine Salad Peach Ice Cream • Chicken Rice Soup Fruit Plate With Cottage Cheese Frosted Brownies	14 Grapefruit Half Bacon Curls • Swiss Steak Baked Potato Buttered Green Beans Garden Salad With Sweet-Sour Dressing Prune Cake With Whipped Cream • Chicken Rice Soup Bacon, Lettuce, and Tomato Sandwich Royal Anne Cherries With Wafers	15 Orange Juice Soft Cooked Egg • Chicken and Dumplings Buttered Broccoli Jelled Cranberry Salad on Endive Hot Fudge Sundae • Veal Loaf Baked Stuffed Potato Lettuce Wedge With 1000 Island Dressing Chocolate Pudding	16 Apricot Nectar Scrambled Eggs, Ham • Roast Pork With Barbecue Sauce Oven Browned Potato Buttered Peas Slaw Applesauce, Cake Squares • Hot Roast Beef Sandwich Diced Vegetable Salad Frosted Brownies	17 Grape Juice Sausage Pattie • Veal Cutlet Snowflake Potatoes Buttered Lima Beans Tossed Vegetable Salad Fruited Gelatin Pie, Graham Cracker Crust, Whipped Topping • Consommé Escalloped Potatoes With Ham Carrot-Raisin Salad Fruit Cup	18 Tomato Juice Soft Cooked Egg • French Fried Haddock, Lemon Wedge Escalloped Potatoes Chopped Spinach Mounds Molded Applesauce in Lime Gelatin Coconut Cupcakes • Vegetable Juice Tuna Fish à la King Baked Sweet Potato Tossed Salad Greens Peach Melba
19 Prunes Scrambled Eggs • Stuffed Flank Steak Roll Whipped Potatoes Buttered Green Beans Sliced Tomato, Lettuce Blue Plums, Cookies • Duchesse Potato Soup California Fruit Plate, Cottage Cheese Nut Bread Chocolate Mint Ice Cream	20 Banana French Toast, Sirup • Roast Turkey, Dressing Mashed Potatoes Asparagus, Hollandaise Sauce Bing Cherry-Nut Salad Pineapple Icebox Cake • Cream of Tomato Soup Ham Salad Sandwich Fruit Salad Plate Honey Cookies	21 Sliced Oranges Coffee Cake • Cube Steak French Fried Onion Rings Buttered Lima Beans Frozen Fruit Salad Date Bars • Chilled Fruit Juice Braised Beef and Noodles Diced Carrots Refrigerator Cheese Cake	22 Pear Nectar Shirred Eggs • Roast Leg of Lamb, Mint Jelly Peas and Tiny Potatoes in Cream Sauce Celery Seed Slaw Peach Pie • French Onion Soup Chicken Salad Potato Salad Fruit Cocktail Chocolate Chip Cookies	23 Berries With Cream Three Minute Egg • Roast Prime Rib of Beef au Jus Snowflake Potatoes Wax Beans Chief Salad With Garlic Oil Dressing Banana Gingerbread Shortcake • Dried Beef à la King on Rusk Buttered Peas, Carrots Apricot Cobbler With Cream	24 Grapefruit Juice Grilled Sausage • Baked Ham Candied Sweet Potatoes With Marshmallow Broccoli, Hollandaise Sauce Waldorf Salad on Endive • Fruit Punch Lamb Pot Pie With Biscuits Tossed Salad Fresh Fruit Cup With Wafers
25 Pineapple Juice Scrambled Eggs • Fillet of Sole, Tartare Sauce Escalloped Potatoes Green Beans Pickled Beets Lemon Filled Boston Cream Pie • Corn Chowder Tuna Fish Salad Potato Chips Tomato Wedges Sliced Peaches With Chocolate Macaroons	26 Applesauce Soft Cooked Egg • Savory Veal Roast Baked Stuffed Potato Buttered Asparagus Fresh Fruit Salad Icebox Cookies • Steak and Kidney Pie Succotash Tossed Green Salad Marble Cake	27 Cantaloupe Half Sausage Pattie • Roast Chicken With Dressing, Gravy Buttered Kernel Corn Cauliflower, Cheese Sauce Applesauce in Lime Gelatin on Lettuce Strawberry Ice Cream • Cold Luncheon Meats Shell Macaroni Salad Hot Biscuits With Strawberry Preserves Peas	28 Citrus Fruit Sections Bacon Curls • Barbecued Ribs Oven Browned Potatoes Buttered Green Beans Slaw Coconut Banana Cream Pie • Vegetable Soup Fruit Salad Plate Cottage Cheese Blueberry Muffin Whipped Raspberry Gelatin	29 Tokay Grapes Scrambled Eggs • Roast Sirloin Strips, Mushroom Gravy Buttered Potatoes Buttered Carrots Garden Salad Neapolitan Ice Cream • Spanish Rice With Bacon Buttered Broccoli Pineapple Ring With Cottage Cheese Tapioca Cream Pudding	30 Bananas in Cream Three Minute Egg • Baked Stuffed Pork Chop Mashed Potatoes Buttered Peas Sliced Tomato, Lettuce Devil's Food Cake, Fudge Frosting • Grilled Canadian Bacon Baked Potato Buttered Kale Cling Peaches With Icebox Cookies
31 Orange Juice, Raisin Toast • Roast Green Ham With Spiced Apple Rings, Snowflake Potatoes, Fruit Salad, Banana Chiffon Cake, With Caramel Frosting • Cream of Mushroom Soup, Toasted Cheese Sandwich, Olives, Pickles, Celery, Carrot Curls, Royal Anne Cherries in Orange Gelatin With Whipped Cream. Ready-to-eat or cooked cereals are offered on all breakfast menus.					



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MAINTENANCE AND OPERATION

Insulation Offers Built-In Dividends

Complete insulation and double glazed windows add to initial construction costs, but more than pay for themselves in terms of reduced size of radiators and boilers, lower fuel costs, and greater comfort for all

CHARLES F. NEERGAARD

THE insulated hospital has an endowment built into its plant. It is cooler in summer, warmer in winter, and uses only half as much fuel for heating. While the better walls and double glazed windows are more expensive, we have found in many hospitals that the savings which the engineer can safely make in reducing the size of his heating boilers and radiators can substantially offset this. Thus, the over-all building budget is not increased, while the halved annual fuel bills yield big dividends for the life of the hospital.

Canadian architects, for more than 25 years, have been using insulation generally. South of the border, in the East at least, we insulate our homes but entirely neglect the acres and acres of walls in all types of large buildings. Each year our hospitals and other large structures are wasting thousands of dollars that might easily be saved with better construction.

My first experience with insulation was in 1932 on Prince Edward Island. There, winters are cold, fuel is expensive, funds are scarce. The architect, James Govan, designed a hospital that has established a dramatic record. The walls were heavily insulated, the windows triple glazed, and the hospital, now with 200 beds, has operated for 26 years on the same two 60 h.p. boilers.

Since then I have consistently urged that all hospitals should be insulated. My first was built in 1935 at Hagerstown, Md. During the years architects

and engineers have repeatedly claimed that insulation and double glazing were prohibitive in cost and that the heating plant could never safely be reduced enough to save the extra cost.

The experience of a few of our hospitals is here assembled to show how radiation and operating costs have been reduced with insulation, and how they might have been reduced still further. It is my hope that these facts and figures will convince the skeptics that insulation pays and is practical.

Complete insulation cuts five ways:

1. It cuts the size of the radiators in half.

2. It cuts the size of the heating boiler in half.

3. It cuts the heating fuel in half for the life of the building.

4. It cuts patient and personnel discomfort from cold walls and windows.

5. It cuts the engineer's fee.

Engineers invariably play safe when designing a hospital, which too often leads to overdesign. Most hospitals are overheated and many are overventilated. There have never been any

TABLE 1—COMPARISON OF THE NUMBER OF GROSS CUBIC FEET IN INSULATED HOSPITALS HEATED BY 1 SQUARE FOOT OF RADIATION AS DESIGNED BY DIFFERENT ENGINEERS IN DIFFERENT AREAS

CONSERVATIVE ENGINEERING	Gross C. F. of Bldg.	S. F. of Radiation	No. of C. F. To Ea. Sq. Ft. of Radiation	Insulation		Approx. Design Temp.
				Walls	Windows	
(A) Bethlehem, Pa.....	750,000	3,750	200	yes	yes	0° F
(B) Glens Falls, N. Y.....	605,000	4,400	137	yes	no	-10°
(C) Hagerstown, Md.....	560,000	3,590	156	yes	yes	0°
(D) New Haven, Conn.....	1,605,000	13,248	121	yes	yes	0°
(E) Prince Edward Island.....	550,000	5,100	107	yes	yes	-10°
(F) Toronto, W.....	1,880,000	16,600	113	yes	yes	-10°
(G) Mount Sinai, Toronto....	3,110,197	30,500	102	yes	yes	-10°
(H) Sick Children, Toronto....	5,874,347	55,100	106	yes	yes	-10°
EXTRAVAGANT ENGINEERING						
(I) Long Island.....	514,000	7,320	70	yes	no	0°
(J) New Jersey.....	425,000	6,600	65	no	no	0°
(K) Virginia.....	1,137,521	23,813	47	yes	no	+10°
(L) New York City.....	2,500,000	49,500	43	yes	no	0°

A, B, C, D, F are additions to existing hospitals. All others are complete new hospitals.

G, H, and L buy metered steam from hospital centers and have no boiler plant.

Mr. Govan, Mr. Daniel and Mr. Neergaard have variously been connected with all of these projects.

Mr. Neergaard is a retired hospital consultant, New York City.



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TABLE 2—MECHANICAL PLANT OPERATING COSTS 1954-55
Comparisons Indicating That Insulation Saves Money

MacNicoll Roswell & Co., auditors for 62 hospitals in N.Y., N.J., Pa., and Md., have furnished uniform 1954 figures for 20 hospitals of from 694 to 279 beds on a patient per capita cost basis. Statistics are weighted:

3 infant days = 1 adult day 3 bassinets = 1 bed

OPERATION OF MECHANICAL PLANT Total (for hospitals #1-20)		AVERAGE COST Per Patient Day	
Salaries and wages.....	\$ 787,046.....		\$0.40
Fuel.....	688,374.....		0.35
Water.....	48,623.....		0.02
Electricity.....	367,599.....		0.19
Miscellaneous.....	279,874.....		0.14
	\$2,171,516 AVERAGE.....		\$1.10

Salaries and wages include only light, heat, power and elevator employees who are 2.19 per cent of total employees.

Total plant expense to total basic operating cost on a per diem basis (omitting special departments—laboratory, x-ray, and so on) is 5.56 per cent.

Owning costs—Amortization, interest, insurance are not included.

**Average Operating Costs for the 20 Hospitals
and Individual Cost of the Five Highest ***

PART	OPERATION OF PLANT					
	Hospital	Beds	Days' Care	Total Cost	Per Patient Day	Total Fuel Cost Per Patient Day
	Group Average					
	1-20.....	6833	1,971,865	\$2,171,516	\$1.10	\$688,374 \$0.35
	#2 N.Y.C.....	556	160,001	233,481	1.46	84,846 0.53
	#3 N.Y.C.....	420	118,417	170,480	1.44	69,010 0.58
	#4 N.Y.C.....	345	97,734	172,956	1.77	41,156 0.42
	#5 N.Y.C.....	262	73,400	100,614	1.37	28,903 0.39
	#15 L.I.....	319	85,704	156,009	1.82	31,355 0.37

*Virtually all of these are steam heated and only three have any insulation in their buildings.

PART II

**HOSPITALS WITH ALL OR PART OF THEIR TOTAL BUILDINGS INSULATED
(HOT WATER HEAT USED)**

Hospital	Beds	Days' Care	Total Cost	Per Patient Day	% Insulated	Total Fuel Cost	Per Patient Day
(A) Bethlehem.....	374	119,299	\$105,232	\$0.92	1/2	\$38,090	\$0.33
(B) Glens Falls.....	252	74,026	52,099	0.65	1/2	12,404	0.167
(D) New Haven.....	383	110,454	96,243	0.07	1/2	25,700	0.23
(E) Prince Edward Island...	210	39,473	37,715	0.96	All	13,859	0.35
(F) Toronto, W.....	725	213,392	183,473	0.86	1/2	51,516	0.244
(G) Mount Sinai, Toronto...	355	114,263	127,933	1.12	All	37,998	0.33*
(H) Sick Children, Toronto...	647	170,017	203,136	1.19	All	76,493	0.45*
(I) New York City.....	170	52,607	108,626	2.06	All	25,852	0.49*

WITH SUMMER COOLING—NO INSULATION

(J) L.I. Jewish.....	224	67,277	135,325	2.02	0	30,305	0.46
(K) Pearisburg, Virginia....	68	15,607	20,325	1.30	0	4,219	0.27

Fuel oil in the states costs \$0.0566 to \$0.066, in Canada \$0.1063.

*G, H, and I buy metered steam from medical center boiler plants. Their fuel costs include owning costs of the plants, which are omitted from the other figures.

generally accepted design standards established.

Charles E. Daniel was retained as consulting engineer by the U.S. Public Health Service in 1943. He formulated certain principles for heating plant design that had proved successful in many hospitals for which he had been consulting engineer.

Mr. Daniel's yardsticks were issued by the Public Health Service to its regional offices as suggestions to architects and engineers and published in

The MODERN HOSPITAL. Unfortunately, they were not incorporated in P.H.S. "Regulations for General Hospitals" which were mandatory on all applicants for grants-in-aid. If they had been mandatory hundreds of thousands of dollars might have been saved annually in the operation of hundreds of Hill-Burton hospitals.

The savings in radiation and operating costs in our hospitals where these principles were followed are shown in the accompanying tables.

The yardsticks are as follows:

Radiation, steam or high temperature hot water: For furred walls, but no insulation, 1 square foot of radiation per 80 cubic feet of building, including inside corridors, storage, kitchen and laundry.

Radiation: As above, except for a building with 3 inch insulation in walls and double glass in weather-stripped windows: 1 square foot per 160 cubic feet of building.

Boiler horsepower (without reserve boiler): Maximum demand winter load, 1 h.p. per bed; maximum demand summer load, 0.4 h.p. per bed.

Fuel consumption: Summer requirements should be slightly less than half those for winter months.

Heating medium: Circulating hot water with a closed system properly zoned is the most flexible, comfortable and economical heat. The water temperature maintained is less than 100° F. most of the time; it can be raised to 200° F. when the outside temperature requires it. Fuel costs, operating costs, and maintenance of hot water systems are minimum.

BOILER PLANT (in principle)

For a 100 bed hospital at 0° F. design temperature, instead of the customary two 100 h.p. boilers, use a 70 h.p. steel hot water boiler and two 40 h.p. 125 lb. boilers. In the event of a breakdown of the heating boiler the two high pressure units at 125 per cent of rated capacity, using a hot water converter for the heating system, can carry the entire load. This installation saves 50 boiler h.p. and upward of \$6000 in initial cost, to say nothing of operating economies throughout the years.

Engineers almost invariably install two boilers in a hospital, each large enough to carry the peak winter load, which entirely disregards the hospital's low steam demand in the six non-heating months. Ever since Mr. Daniel conceived the idea of this flexible three-unit boiler plant in 1916 for Mount McGregor Sanitarium, New York, he has followed this practice.

HOW BUILDINGS WERE INSULATED

The four pioneer hospitals A, B, C and D were insulated as follows:

The walls had a U factor of .095.*

(Continued on Page 124)

*The U factor is the over-all heat transfer coefficient through materials in terms of Btu. (British Thermal Units) per square foot per degree Fahrenheit per hour.

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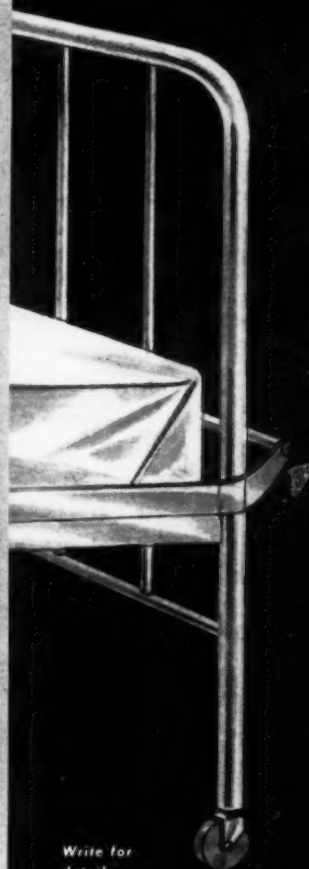
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WHAT OTHER PEOPLE THINK OF INSULATION

You have made a convincing case for insulation and a more measured judgment in providing radiation for hospitals. The real problem is to kill the rule of thumb which has always included an excessive factor of safety.—Harold D. Hauf, chairman of architectural group, Rensselaer Polytechnic Institute.

Your article on insulation should be required reading for hospital engineers and architects. There are too many areas of accepted practice which are not based on need or reason. In these days of rising costs every expense must be examined and reexamined. Waste of any kind in a hospital plant is inexcusable, be it through the walls or up the chimney.—Albert W. Snoke, M.D., director, Grace-New Haven Hospital, and president, American Hospital Association.

I fully agree with your presentation of the case for insulation as a means of economy of operation and in first cost of heating installations. Insulation always is a worth-while investment and repays its cost many times in the lifetime of a building by reduction of fuel costs, not to mention the benefit of more comfortable conditions.—David M. Hummel, manager, Div. Engineering, Planning and Estimating, Yale University; lecturer on mechanical equipment, Yale Department of Architecture.

(Continued From Page 122)

In cross section there was a 12 inch brick wall waterproofed on the inside; a 2 inch air space; a 3 inch fireproof furring slab of wood fiber and Portland cement 30 by 80 inches with $\frac{3}{4}$ inch of plaster applied direct. The roofs had similar protection. This construction was simple, economical and effective. The windows, about 30 per cent of the wall area, were tight metal, well gasketed and glazed with $\frac{1}{2}$ inch double pane.

The four building contractors who erected these structures reported that the savings in radiation and boilers substantially offset the additional cost of the walls and windows.

Hospital H in Toronto is mechanically ventilated throughout and has 24 supply and 48 exhaust systems; 78,700 C.F.M. of 100 per cent fresh filtered preheated air is supplied with no recirculation except in the auditorium. The plant is designed for the future addition of cooling.

Hospital L has an elaborate system of ventilation under the New York City building code for interior space and occupancy. Fourteen fans supply 165,000 C.F.M. (60 per cent recirculated); 23 fans exhaust 159,000 C.F.M., total fan h.p. 140. The four lower floors and surgery, about half of the total building, are air-condi-

tioned. It has a modified double corridor plan; the four lower floors are used for clinics and auxiliary services.

The data assembled in Table 1 and discussed as follows support the thesis that, given adequate wall and window insulation, the engineer can cut the size of his heating plant at least in half. The data also indicate how widely engineers vary in their design practice in allowing for insulation.

Hospitals A, B and C, engineered by Mr. Daniel, confirm the validity of his formula that, for 0° F. design temperature, 1 square foot of radiation will heat 160 cubic feet in a fully insulated building.

INDICATES HEATING ECONOMY

The Bethlehem Pavilion (A) of five stories, with the highest ratio (1 square foot to 200 cubic feet), uses the double corridor plan and indicates the heating economy of this layout. In the 14 foot service area between the corridors are eight utility and plumbing units on the four patient floors and no radiators. With the single corridor plan each utility would have been on an outside wall and 32 radiators would have been required. For the original building before enlargement, four $1\frac{1}{2}$ h.p. two-speed exhaust fans on the roof supplied satisfactory ventilation. Ducts were installed for

future air supply and limited air conditioning but never used.

In the four Canadian hospitals, E, F, G and H, designed by James Govan, the several engineers used far more radiation than the insulation justified or the lower design temperature warranted. Mr. Govan's comments on Canadian practice are relevant:

"Engineers generally fail to make anything like adequate allowance for the time lag heat capacity factor in buildings due to insulation and double glazing. . . . If Canadian engineers were not so influenced by heating practices in the U.S.A., they would make very much greater reductions in the amount of radiation provided in well insulated buildings in Canada."

Comparison of plant operating costs are influenced by many variables—the size, age and construction of the buildings, the efficiency of the plant and its operation, the design temperature, cost of fuel, and so on.

It is unfortunate that the cost of heating the insulated Pavilions A, B and D cannot be segregated. When comparing the operating costs of the entire plant the savings effected by one insulated pavilion can be only suggestive.

For example, Bethlehem has seven or eight widely scattered old buildings with more than three times the bulk of the new wing. Its boiler plant is conventional.

New Haven's five older structures are spread around an entire city block. Its operating costs would have been considerably less if the engineer had made the full reduction in his radiation which the insulation warranted. Its boiler plant is conventional.

Glens Falls, compact under one roof and with a flexible boiler plant, even with only its walls insulated is the best example of what an insulated addition can accomplish.

The operating figures in Part 2 of Table 2 furnished by the eight hospitals with more or less insulation are adjusted to conform to the auditors' standard accounting. The expenditures of these eight hospitals, when compared to the average of the 20, demonstrate that insulation pays! The auditors estimate that the total mechanical plant operation on a per diem basis is 5.56 per cent of the basic operating expenses—a relatively small percentage—but consider this. If the 20 hospitals averaging \$1.10 a patient day were as economical to run as Glens Falls, which spends 65

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City _____ Zone _____ State _____

cents per patient day, the annual savings would aggregate \$900,000, or 4 per cent interest on a \$22,500,000 endowment.

Another comparison: If New York hospital No. 2 with 556 beds has to spend \$233,400 for plant operation, and Toronto Hospital (F) with 725 beds, with less than half its buildings insulated, spends only \$183,400 a year with a 10° F. lower design temperature and 5 cents per gallon higher oil cost, insulation is valuable. Toronto Hospital used 450,000 gallons of fuel oil at \$0.1063 a gallon. At \$0.066, the cost in the United States, it would have saved \$18,000 and reduced its plant operating cost to \$165,400, as compared with \$233,400 for the New York hospital with 169 fewer beds.

HAS TWO HEATING SYSTEMS

Hospital L, with half of its building air-conditioned, has two systems of heating: 10,500 square feet of direct hot water radiation (1 square foot to every 204 cubic feet) for the building; and 39,000 square feet of indirect radiation to heat the 165,000 cubic feet of induced air, nearly four times as much as for heating the building. The total radiation is 49,500 square feet. The resulting operating cost of \$2.19 per patient day is the highest in the group. The hospital's large outpatient attendance as related to its inpatient days should be considered in the unit cost.

The operating costs of Hospital L are suggestive of the costs that hospitals face if they install air conditioning.

Canadian hospitals are planned for lower temperatures. They pay nearly twice as much for fuel oil and use more of it.

The dramatic operating record of Prince Edward Island Hospital (E) indicates clearly that its radiation could have been materially reduced.

During the winter of 1934-35 a daily chart was kept of outside temperature, average temperature in the building, temperature of the circulating water, wind conditions, and fuel burned.

The walls have a U factor of .106. The windows, 2¾ inches thick, have three-gasketed ⅞ inch sash that can be opened for cleaning. The windows probably have as much to do with the spectacular operating results as the wall and roof insulation.

The engineer designed the system to circulate water through the radia-

tors up to 200° F. but the chart shows an average of only 108° F. throughout the winter, which maintained a building temperature 70° F. or higher. On January 17, with an outside temperature of 20° F. below zero, the circulating heating water rose to only 130° F. In three days of below zero weather in December, with a low of -18° F., the heating water averaged only 136° F. High winds and blizzards had little effect on comfort and, with rapid temperature drops to below zero, there was a time lag of from three to five days while the heating water temperature rose from 108° F. to only 140° F.

The engineer had reduced the radiation by 57 per cent of what he would have normally provided there to compensate for the insulation and triple glazing, but it is obvious from the operating experience that a much larger cut was warranted.

The 135 bed Virginia Hospital (K) illustrates both a common attitude toward insulation and tragic overdesign.

Both architect and engineer had planned many hospitals. The heating plant was only one of many wasteful errors. The consultant suggested the advantages of insulation, double glazing and the three-unit boiler plant. The committee approved insulation, but not double glazing, as the engineers fallaciously reported it would take seven years to amortize its extra cost out of fuel savings. The suggested three-boiler unit, aggregating 200 h.p., was vetoed as the engineers reported that it would cost more than the 400 h.p. in two boilers which they recommended.

They installed a forced 100 per cent fresh air ventilating system, entirely unnecessary with the hospital's open country site. This required 13,000 square feet of indirect radiation to heat the air, in addition to excessive radiation provided to heat the building. The plant went in over the consultant's protests. Result: an insufferably overheated building and more than a hundred thousand dollars of hospital money wasted.

Just consider these comparisons. If the New Haven Hospital (D) could adequately heat 1,600,000 cubic feet with 13,248 square feet of radiation for zero design temperature, why should the Virginia building, with 1,137,000 cubic feet, be overloaded with 23,800 square feet of radiation for a design temperature of 10° F. above zero?

Virginia, as an example of inexcusable waste, is only surpassed by a hospital recently studied in the Middle West, where \$200,000 was thrown away by the engineer and architect.

The first cost of overdesign, with or without insulation, is suggested by the current allowance quoted by a leading New York heating contractor of from \$10 to \$12 a square foot of radiation for budgeting a hospital heating plant, including radiation, boilers, equipment and labor.

Hospitals J and K have no insulation but their relatively low operating costs for year-round comfort and cooling are suggestive.

Long Island Jewish Hospital, with the double corridor plan, has panel heating and panel cooling with coils in the ceiling. Deep well water is used for the cooling. The per capita cost of \$2.02 per patient day is probably one-third less than would be the case with conventional air conditioning.

From the standpoint of comfort and probable cost, panel heating and cooling is ideal for hospitals and is long past the experimental stage. The main problem is controlling the dew point.

FIRST TO INSTALL HEAT PUMP

The little Hospital K at Pearisburg, Va., was the first in the country to install a heat pump. Reverse cycle refrigeration, which draws both heat and cold from air or water, is rather incomprehensible to the layman and generally unexplored by hospital engineers. Pearisburg enjoys satisfactory year-round comfort, with a per capita cost of \$1.30 per patient day.

What can be done about all this? Investment counsel safeguards the hospital's portfolio, but rarely does the investment of several hundreds of thousands in its mechanical plant receive more than perfunctory appraisal in the blueprint stage. The hospital can sell defaulting securities, but its mechanical plant is in "for keeps." Many check the architect's plans for arrangement and adequacy; there is rarely competent review of the engineer's recommendations to ensure that the hospital gets a plant that will prove effective, simple and economical during the many years of its life.

Hospitals too long have paid dearly in cash and discomforts for failure to adopt new and better ways of doing things, yet they can never afford to

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Better Things for Better Living
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take chances with less than well proven innovations. Three features of hotels and office buildings are being advocated for new hospitals: large glass areas, curtain walls, and year-round air conditioning, all of which benefit by insulation.

GLASS

The hospital has found conventional size windows approximating 30 per cent of the wall area satisfactory in use and practical from the cost standpoint to double glaze. In a hospital excessive glass areas are not desirable

and double glazing is prohibitively expensive. The patient wants subdued light, quiet and comfort. Large glass areas bring glare and more noise from larger venetian blinds and radiate chill. They require more cleaning and more steam since 1 square foot of glass takes four times as much heat as a square foot of insulated masonry wall.

CURTAIN WALLS

This new type of building envelope saves time in erection and gains floor space. How it will wear and weather only time will tell. Designers have

apparently overlooked the economy in heating and cooling which adequate insulation would provide.

A recent report of the Princeton School of Architecture, "Curtain Walls of Stainless Steel," describes in detail the walls used in 28 buildings. The heat loss coefficient is given for only 15 of these. Six have U factors which range from .11 to .16 and nine from .18 to .24. All of these mean a lot of heat going and coming through the walls. Builders aim at a U factor of .085 in the walls of new homes. Why not the same protection for hospitals and all big buildings?

If these walls had 2 inches of insulating bats the heat loss in most cases would have been more than cut in half.

In a recent paper, "The In Place Cost of Walls," Hayden T. Noyes of the Turner Construction Co. describes in detail the walls used in 11 buildings. No U factors are given.

A dramatic new 42 story office building in New York had curtain walls of 20 gauge stainless steel panels, 4 inch cinder block backing, 1½ inch to 3 inch air space, and 1 inch of glass fiber insulation. Approximately 18 per cent of the wall area was in metal windows glazed with ¼ inch plate, which are included in the cost of the wall in place of \$7.20 per square foot.

An engineer computed the heat loss transmission through these walls and windows. The wall had a U factor of .13. If 2 inches instead of 1 inch of glass fiber had been used, the U factor would have been reduced to .084, cutting the heat loss through the walls by more than one-third at an additional cost of only 25 cents a square foot. If ½ inch double glazed pane at \$3 a square foot had been substituted for ¼ inch plate glass at \$1.50 a square foot, the heat loss factor would have been cut from U 1.15 to U .58, reducing the heat loss through the glass by half. How much could be saved today in these big buildings in the first cost of the heating or air conditioning plants if more were spent on the walls and windows is a question that should be answered. The operating savings will inevitably continue through the years.

AIR CONDITIONING

General air conditioning is being considered by many new hospitals in spite of the large increase involved in the capital and operating budgets.

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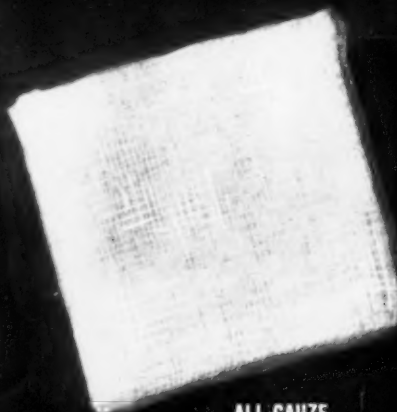
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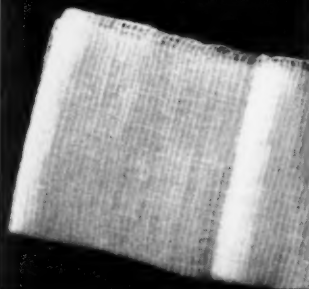
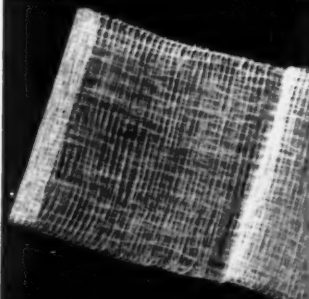
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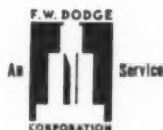
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THE FIRMS LISTED at the right have filed catalog information in the 1957 edition of HOSPITAL PURCHASING FILE—to help you, your purchasing officer and department heads make wise product selections.

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Engineers have frequently claimed that insulation and double glazing were not necessary or practical where this was used. Week-long summer tests, in three of our hospitals, with recording thermometers have shown that the insulated pavilions average 8° F. cooler than the uninsulated buildings adjoining. It would take a lot of refrigeration and fan horsepower to lower the temperature in a 2 million cubic foot building 8° F. when the outside temperature was 90° F.

This study of insulation and heating plants has been based on a few

widely varying, widely scattered hospitals designed by different architects and engineers 15 or 20 years ago. The pioneer buildings have only three things in common: adequate insulation, reduced heating plants, and low fuel consumption. The facts and the figures can be only suggestive but they clearly indicate the desirability of organized research in the interest of hospitals and the national building economy generally.

The John B. Pierce Foundation Laboratory at Yale was established for the promotion of research in the gen-

eral fields of heating, ventilation and sanitation. Dr. L. B. Herrington, its director of research, commenting on this paper, writes:

"Your data confirm my impression of a widespread tendency to over-design, and a lack of clear-cut conceptions as to the optimum combination of insulation costs, capital cost of the heating equipment, and operating cost. Even granting that a stable formula for the optimum combination is difficult to arrive at during a period of changing costs and new building designs, I still think that your general position is well taken."

While this study was carried out primarily in the interest of hospital economy it suggests great possibilities in the housing field where thousands of tenants would profit as against one patient in a hospital. Housing authorities are building groups of identical multistory units which present a rare opportunity for research and demonstration at practically no additional cost.

Some years ago London built two identical branch post offices to determine the relative economy of "panel warming" and circulating hot water heat. The building with "panel warming" uses 40 per cent less fuel than the other.

Consider the challenge and invaluable data that would emerge if a group of identical multistory apartments were each designed by a different team of architects and engineers, bringing their varied experience to a comparative demonstration. For example, if two buildings were panel heated, one with insulation and one without, and the same carried through for circulating hot water, vapor vacuum and steam, and several types of air conditioning, not only would the comparative first costs be known but in one season the relative maintenance and operating cost would be proved. Such a project would afford comparisons in many different details of construction, such as insulation, windows, flooring, and so on.

The U.S. Building Research Advisory Board is studying ways and means to effect conservation in building. Here is an agency already in being that might expand its field to the evaluation of insulation versus heating which would contribute immeasurably to the national economy in the hospital and housing field and at practically no cost for research—and the nation needs to save.



Strict and consistent accuracy in the measurement of bloodpressure is difficult to achieve at best. If just one possibility for compounding error can be eliminated, why not?

The mercury displacement principle in sphygmomanometry excludes the possibility of functional error in the instrument itself. It does not depend on the elasticity of metal, which varies, or on moving parts, which wear. Its action is governed solely by gravity—the most constant and unequivocal force known. As such, it provides the standard against which other types of manometers must be calibrated and checked when their accuracy is in doubt.

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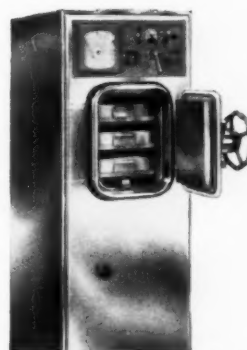
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HOUSEKEEPING

A Training Program for Housekeepers

7. How to Teach Service Personnel

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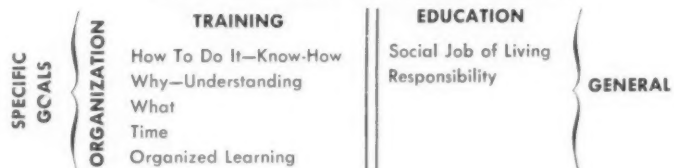
ALL the things listed under "Training" in the accompanying diagram will be discussed in this program and, when you leave the class, I am sure every one of you will be capable of doing the cleaning procedures as a member of a coordinated team.

Under "Education" are listed two things I can do little about at this stage of your lives, although I may be able to help by guiding or changing your mental attitude in some situations.

However, this "Social Job of Living" means your background: how you were reared as a child; your standards and ideals; your ability to adapt to the

Mrs. Mills is director of housekeeping services, St. Luke's Hospital, Chicago. In this article, seventh in a series, she shows her housekeeping trainees how she teaches new procedures to aides and housemen.

GOALS OF EMPLOYEE TRAINING PROGRAM



laws of society. For instance, you don't go to church in a bathing suit. Why? That's right—social customs say differently. When you go to the store, you don't just walk in, help yourself and walk out without paying or charging it on your monthly bill. If you do, we call it stealing. You must pay for value received.

Now about "Responsibility." When you see a man begging, what do you think about such a person? Is he being

responsible for his life's problems? No. He is shirking his responsibilities by not getting a job and working for a living.

General education, of course, means education in school or at work and learning from the everyday situations that arise in our lives. These situations can be most valuable if we will capitalize on them and learn something new from each one.

Training begins when there is something new to learn; training for the sake of training does not mean much. So you will find it necessary to put all else out of your mind. What you are going to have for dinner or where you will meet your best girl will have to wait if you get this right.

One of the first things you must learn is skill in copying—get it right—and the art of observation. Look at it carefully before you say it is completed or you are finished.

This training course is to teach you the various new methods of cleaning which will be started on the patient floors when you finish with this training.

Now you are probably saying, "Why all the fuss about cleaning?" and perhaps one of you men thinks, "This is funny; come to school to learn how to sling a mop." Well, basically there is a little more to it than that, for I



Under Mrs. Mills' watchful gaze, her students complete their notes. Left to right: Elizabeth Fullerton, trainee; Alice Scott, Catharine Martin, Georgette Prairie, assistant supervisors and senior students; Opal Manny, supervisor of procedures, and Jessie Robertson, a trainee, at work at St. Luke's Hospital.

when you count
the cost of
replacement

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In the long run, the more equipment you have made of Crucible Stainless, the more economical your hospital will be. *The Crucible Steel Company of America, The Oliver Building, Mellon Square, Pittsburgh 22, Pa.*

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would like you to know *why* I believe this training is necessary to give you the incentive to do an outstanding job. I want you to realize that the guest or patient is the main objective for any training, the end result being better patient care.

You have been given a sheet outlining the equipment you should have stored in your locked closet on each floor. This equipment list has a place for both the aide and the houseman to sign, and you are responsible for this.

You will note that we have just two items for general cleaning: detergent and paste cleaner. I should like to show you how to use this material. You will note we do not use rags, but sponges, for wet work and a chemically treated duster for all dry dusting. We rent this duster at a small cost. It lasts you two weeks and takes the dust and dirt right out of the area; it does not just move it from the desk to the air or floor. With this type of duster there is no need for carrying a pail of water on your carts. If you need to remove some sticky spots, just wet the sponge from the basin in the room.

You have found that sponges and this kind of duster eliminate considerable of the bending that used to be necessary to do damp dusting. You realize now that they clean better than any old cloth you happen to get on supply day. You don't have any more bags of clean and soiled cloths to store in your closet.

You have an outline for the uses of the detergent, and I will read it with you carefully so you will understand the importance of emulsification (you learned that word long ago). We will learn by demonstration the best ways to use detergent.

Paste Cleaner. This material is to be used on tile walls, bathroom fixtures, stainless steel, or anything else that is made of metal, including your galvanized buckets. Do not use it in water; it will not dissolve.

Dampen your sponge; dip it in the can. Go over surface of object and rinse. When the cleaner is not in use, keep damp sponge on top of the paste, inside the can. You do not take the toilet brush, get it full of cleaner, and then try to clean the toilet. That would be wasted time and effort.

Detergent. Follow instructions as listed on the general cleaning purposes instruction sheet for amounts to be used (half cup for aides, 1 cup for

GENERAL CLEANING PURPOSES INSTRUCTION SHEET

CLEANING PROCEDURE AND SOLUTIONS

This cleaner is a synthetic, neutral cleaner which, when used correctly, will meet all your general cleaning problems without any damage to surfaces and with the least possible labor, time and expense. You will note that this cleaner—with all of its cleaning ability—has a pH of only "slightly alkaline." Consequently it is definitely a safe as well as a powerful cleaning material.

However, one must always be guided by the fact that this cleaner depends primarily on the principle of emulsification for its cleaning ability, and thus, when used in a straight form or in a stronger solution than outlined, can strip a floor of wax, remove paint and various types of stains. Always remember when this cleaner is used in the straight form the surface should be wiped off with clean water. Otherwise no rinsing is needed.

PROCEDURES FOR CLEANER:

1. Always use cleaner in the straight form when making up solutions—do not dilute when issued from the original drum of cleaner.
2. No rinsing is needed except when used in the very strong solutions and in these instances the area should be wiped off with clear water.
3. Cleanliness is most important. Be sure that the solution is changed often and that mops and cleaning cloths are clean and kept clean.
4. Always remember to keep the container of cleaner covered or closed, for it will evaporate when left exposed to the air over a period of time.

SOLUTIONS FOR VARIOUS REGULAR CLEANING PURPOSES:

FLOORS	HOUSEKEEPING AIDES	HOUSEKEEPING HOUSEMEN
Tile	$\frac{1}{2}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water	1 cup cleaner to a large double bucket $\frac{3}{4}$ full of warm water or to the bottom of wringer
Linoleum		
Asphalt tile		
Mastic tile		
Marble		$1\frac{1}{2}$ or 2 cups cleaner to same solution as above
Italian marble		
Cement		
Application: Mop, scrubbing machine or brush		
WALLS	HOUSEKEEPING AIDES	HOUSEKEEPING HOUSEMEN
Tile	$\frac{1}{2}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water	$\frac{1}{2}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water
Application: Apply with a scrub brush or soft cloth and wipe clean		
Painted	Same as above	Same as above
Application: Apply with a clean soft cloth, cleaning in a sweeping motion left to right or right to left. You may start from the top and come down or vice versa		
Papered	$\frac{1}{4}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water	$\frac{1}{4}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water
Application: Apply with clean soft cloth in up and down motion and wipe clean and dry with a soft dry cloth. You may start from the top down or vice versa		

When washing walls apply the solution with discarded bath toweling and both blanket or some similar material. Do not use sheeting or any hard surface material. This type of material does not absorb and has a tendency to break the paint surface. You will note that the procedures for cleaning shown above are usually in keeping with the manner in which the wall surface has been applied—i.e. painted walls as a paint brush is used—left to right or vice versa.

If these small details are followed, wall washers will have no difficulty when following each other for their procedure of cleaning will be in the same manner as that of the ones preceding them. This makes less work for the wall washers as they will not have to clean against an opposite cleaning movement or streaked area.

For washing large and difficult wall areas use regular wall washing chemicals.

(Continued on Page 138)

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housemen) and different size buckets. Have bucket $\frac{3}{4}$ full of warm water, just below the wringer, so that you don't wring into the water. Do not rinse with this solution. Put detergent in bucket first and run lukewarm water over it to mix the solution. Boiling hot water on this detergent kills all the working properties and you'll break your back rubbing. Let the detergent do the work for you. Remember, the less water you use on the floors, the better the floors will look and the easier the upkeep will be. Wring mop several times, and it will be wet enough to clean the floors. There will be no need to go back and "dry up."

PROGRESSIVE CLEANING

Progressive cleaning means that you learn to clean so that every movement counts. If we are going to progress, we must establish a pattern or form for this type of cleaning. You will find yourself constantly moving forward, not backtracking in your work or repeating your efforts. This takes a little thought at first, but try to make each step and movement count. For instance, when you dust a table I see you stand and go back and forth, back and forth, over the same area. Why? If it is just dust you want to remove, you can do it in one swish, but you are working as if you wanted to remove the finish of the table. Instead, take the duster in the palm of your hand and two strokes will do the job. Repeated rubbing does not help; it only takes up your time and wastes your energy.

Bathrooms. Regardless of how you clean the bathrooms now, this is the way I should like to see you try to learn to do them from now on. Let's clean one of the large bathrooms on a ward floor, with six face bowls and six toilets. Usually the toilets are farthest from the door and the face bowls nearest. If this is the case, start with the toilets, so you can work all the time toward getting out.

Take a cup of detergent, flush toilet, raise the seat, pour a small amount of detergent in each toilet and let stand until you have completed all six. Return to first toilet with sponge, clean seat top, raise top to do underside. Clean top and back of stool, and then the outside and base. Take brush from your cart at hand and clean the inside of the toilet, getting well under the lip of the upper edge. You have a detergent in this toilet; let it help you with your work by allowing it to stand as

CLEANING INSTRUCTIONS:

(Continued From Page 136)

SOLUTIONS FOR VARIOUS REGULAR CLEANING PURPOSES:

FURNITURE	HOUSEKEEPING AIDES	HOUSEKEEPING HOUSEMEN
Various types of furnishings	$\frac{1}{2}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water	$\frac{1}{2}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water

Application: Apply with a soft cloth and wipe dry. No rinsing needed

When furnishings are in a very bad condition with accumulated soil or spillage the following procedure saves time and labor:

Dampen soft cloth and put a small quantity of straight cleaner in the middle of the cloth and then rub the cloth together as you would a polish. Apply direct to the area and watch the lightening results. When all the dirt has been removed reverse your cloth, which should be just damp and free from all cleaner, and wipe the surface free from the straight cleaner. When straight cleaner is used the application is sometimes spotty and, in this event, the strong solution remaining over a period of time would remove the original surface.

GLASS	HOUSEKEEPING AIDES	HOUSEKEEPING HOUSEMEN
Tops and cubicles	$\frac{1}{4}$ cup cleaner to a small single bucket $\frac{3}{4}$ full of warm water	Same as the aides

Application: Apply with clean soft cloth and wipe dry

FABRICS

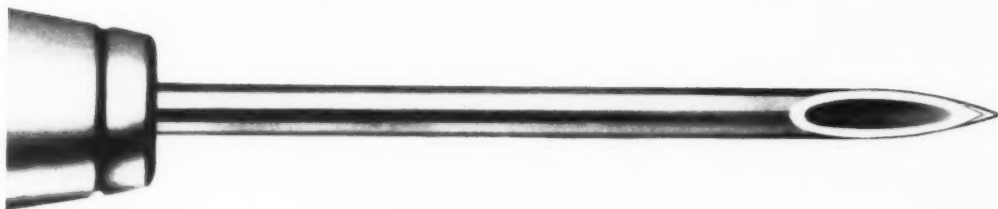
Because there are various types and colors, I would suggest you refer your problem to the housekeeping department. The quicker you can advise us of the spillage or accident the better opportunity we have to overcome the problem.

PROCEDURE FOR CLEANING WITH VACUUM

ESSENTIAL STEPS	SPECIFIC INFORMATION
I. Aide who has vacuum first (8 a.m.) (a) Bathroom and lounge first (b) Set up vacuum with cleaning equipment	<ol style="list-style-type: none"> 1. Service with toilet tissue and paper towels. Pick up and tidy only. 2. Clean lounge, empty wastebaskets and ash trays, vacuum floor. <ol style="list-style-type: none"> 1. Start vacuuming where there is the least confusion. 2. Try to avoid breakfast trays, keep from underfoot, watch for doctors and consultations. <p>(After she has mastered technic of vacuuming, the aide should be through with vacuum on her floor at about 10:00 or 10:30. Do not go on break until rooms are vacuumed—houseman until rooms are mopped.)</p>
(c) Move vacuum to second area	<ol style="list-style-type: none"> 1. Vacuum tools move with vacuum.
(d) Progressive dusting	<ol style="list-style-type: none"> 1. Circle the room from left to right or right to left. 2. Dust cloth chemically treated, for dry dusting only. 3. Sponge for damp work.
(e) Equipment	<ol style="list-style-type: none"> 1. Leave cart outside door in small areas. 2. No buckets, no water needed on cart. (Use face bowls in rooms.) 3. Mop buckets used only when mopping (do not carry mop bucket on cart). 4. Vacuum hose—two lengths to allow machine to remain outside of door. 5. Dirt filter bag must be vacuumed or swept nightly. <ol style="list-style-type: none"> (a) To clean: Have a standard paper vacuum bag available to put in the bottom of machine before emptying dirt. (b) Replace motor and vacuum filter bag with end of hose.

(Continued on Page 140)

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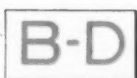
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long as possible. Work your way toward the door so that you arrive, without having to backtrack, at the face bowls.

Leave the can of cleaner on cart. Take the sponge that is in the can and dip up some of the paste. Start with the face bowl farthest from the door. Clean each bowl, including the nickel, well; work your way toward the door. Perhaps you have needed more cleaner during this time and, of course, since your cart is right behind you, it has been easy to dip up some more on your sponge. When the cleaning process has been completed for all six bowls, go back to where you started and, with your sponge, rinse off the paste cleaner. Polish the nickel and mirror and work your way toward the door. Since your cart has been moved right along with you, it is ready to be pushed outside. Any problem? What if someone comes in to use a bowl? Why not? If the bowl you have the cleaner in is used, you will have less work rinsing it off, and if the first bowls are used, you have yet to clean them.

But just don't stand around and wait if someone is using a bowl you have not cleaned. Get busy and either rinse the bowls you have done, or start work elsewhere and come back.

Now you say: "We need clean rags to clean the nickel and mirrors. You can't clean a mirror with a sponge nor can you polish the nickel with a sponge." Well, right near the face bowls are boxes for paper hand towels. Take a couple and polish your mirror. This does a beautiful job, and if you still feel you have to keep going back over your work to get results, use the same paper towel for the nickel but your sponge will wipe it sufficiently dry to make it shine and not spot.

Mopping. I believe there is a right and wrong way to mop. Will one of you please walk across the room? Fine. Now what did you do? "Just walked." Well, how did you walk? "Put one foot ahead of the other and my arms just swing." Did you stop and think which foot went out first and which arm went back? "No, you just do it that way."

That is known as rhythm and balance of your body, and you should do your work in the same manner instead of getting all bent over, "slinging a mop" from side to side. Stand straight and put one foot out ahead and the other one back a bit, and now rock up on your toes and back on your heels.

Supervisor checking equipment

Washing checkout beds.

Cleaning glass cubicles, mirrors, chrome and so on.

Ward corridors—P and SP Main

Lobby aide — Cart, bucket and mop.

II. Aide who has vacuum second (10 a.m.)

(a) Empty wastebaskets

(b) Clean bathrooms

(c) Clean lounge

(d) Vacuum

When houseman finishes his mopping on this second floor, patient areas, auxiliary rooms and halls, he will return to finish his auxiliary rooms, halls and other general work on the first floor or wherever he worked first that day. The aide does all the dusting and general cleaning above the floor. The houseman has the responsibility of lights, high dusting, cubicle curtains, handling of draperies, changing of mattresses, and heavy moving on his two floors.

Hum a little tune until you get the swing. I like "Darktown Strutters Ball." It has a good beat.

Dusting. Progressive dusting and cleaning of a room should go some-

PROCEDURE FOR CLEANING WITH VACUUM

(Continued From Page 138)

(c) Remove paper bag, empty dirt, and wipe paper bag with a paper towel. Clean can and store vacuum equipment.

(d) Last person using the equipment must clean.

(e) **Washing Filter:** When vacuum is used in two or more areas the filter should be washed on the night designated (Saturday by alternating personnel; vacuum not used on Sunday).

Method for Washing: Use sink in service room or wherever available. Allow to soak 15 or 20 minutes in $\frac{1}{2}$ cup detergent to $\frac{3}{4}$ bucket of water. Do this while cleaning vacuuming equipment. Then scrub in rotating manner with scrub brush. Rinse well, hang on hook in HK equipment closet.

(f) Small bag containing extra cleaning tools should remain tied to the handle of the motor.

(g) Hose should be stored in the bottom of vacuum with the filter bag resting on outside top of motor.

Check washing of filters on Saturday.

Check filter for cleanliness during every 4 p.m. equipment check round.

Personnel should be on the floor when this check is made.

New vacuum machine: The cord should be wound (not too tightly) around the handle of the machine.

Every girl should have a paper vacuum bag for use in vacuuming of filter bag.

Mops must be washed before being put away for the night.

Use basin on cart. Use 2 caps full of detergent mixed with warm water.

Use sponge and dry with paper towel (eliminates extra cloths).

Aide will dust mop with treated dust mop in afternoon.

Houseman will wet mop around edges.

May need to carry a mop and bucket on her cart.

1. Put disposal bag over aide cart. Leave cart at side of door. In small areas bring two baskets with you to the cart at one time.

2. In large wards take the cart in the ward with you, emptying wastebaskets as you go.

1. Clean thoroughly. Not just pick up.

1. Dust and empty wastebaskets and ashtrays.

Keep from underfoot. Watch for doctors and consultations. Proceed with vacuuming.

thing like this. You all know that when you enter a patient's room your movements should be both few and quiet for the good of the patient.

Do the bathrooms first, in the same



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manner as we outlined the work in the large bathrooms. If there is no bathroom, do the face bowl in the room. When all damp work is out of the way, take your duster and circle the room from left to right or right to left. Don't rush over to the window sills and wipe them off, then do the bedside table and chair, and then go back to the desk between the bed and the other wall. Make each stroke and each step count.

Start with the first piece of furniture at the right of the door and go around the room, taking the window

sills as they come in the circle. How do we do this dusting? For heaven's sake, stop patting it to death! Let's take the dresser as an example. Begin at the front with the duster flat in your hand; take one, two, three strokes. Now you are at the back of the dresser; swing up to the right of the mirror, around the frame, and down that side of the dresser and legs, across the front, and the left side of the dresser. Now, you are right in position to do the next piece of furniture. What difference does it make whether you do the mirror left or

right? Really none, except if you go to the left side, you are going backward in your movements. You end up by the door, and you are not going that way.

I see you practically on your knees dusting a chair; why aren't you smarter than the chair? A chair does not even have the ability to think, yet it has you on your knees. If you are going to wash the leather seats of a chair, get your sponge and do it. If you only need to dust the chair, one stroke of your duster will get the dust off. Spots and sticky places won't come off so easily, of course.

Now face the chair. Start at the part closest to you. Move toward the back of the chair, then swing up around the back, and down the open part or cut-out work of the back. Now it is time to do the underneath part of the chair. Unless you are doing a big lounge chair, with one hand tip the chair up on one front leg, the one farthest from you, and spin the chair around, dusting as it goes. You will have to bend a little, but it certainly will not give you a backache nor will your joints ache from getting up and down.

In other words, whenever it is possible bring your work up to you. I have seen you clean footstools on the floor. Why? Bring them up to a working level. If it is a check-out room, the footstool can be placed anywhere to be cleaned. If the patient is still in the room put it on your cart, on the ledge of the face bowl, or on the desk chair. Just don't put it on the bed with the patient.

Let's all try dusting a straight chair so you can get the hang of it. It looks easy until you try. Tonight you can practice with your kitchen chair. You all did very well for the first time and had a lot of fun watching one another. Perhaps you found out that "He who laughs last laughs best!"

There will be a team doing this progressive cleaning: one aide and one houseman. The aide is responsible for one floor, the houseman is responsible for two floors. We are going to learn to do our sweeping with a vacuum. The aide will do the vacuuming, and the houseman will do the mopping. The vacuum must be used between the two floors for which the houseman is responsible. In order for the work to flow evenly, one floor starts with the vacuum the first thing in the morning and the second floor gets it about 10 a.m. to 10:30 a.m.



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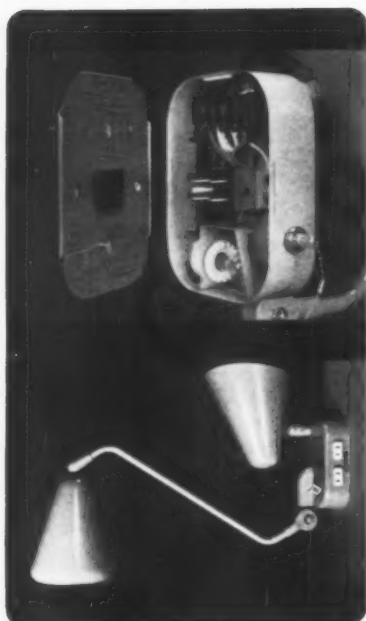
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Impact of Heart Surgery on Hospitals

(Continued From Page 70)

tire brilliant picture of modern heart surgery has had innumerable and often anonymous contributors. The key to this development has been and remains the team approach to the problems involved. The hematologist makes blood transfusions safe; he has clarified the mysteries of coagulation. The bacteriologist continues to emphasize asepsis while providing us with new and better antibiotics. The medical cardiologist has developed newer and more accurate diagnostic facilities and technics; he provides invaluable preoperative and postoperative medical management. The anesthesiologist provides safe, effective anesthesia for our long and difficult procedures. The roentgenologist has developed the technics of aortography and angiocardiology

which have sharpened our diagnostic abilities. Scrub nurses, technicians, supervisors, biochemists, physiologists, physicists and administrators all have individual and important rôles to play. All have helped the cardiovascular surgeon in his rapid progress.

What of the future? We have crossed the threshold and have entered into fields of boundless opportunity. Cardiovascular disease is the most important cause of death and disability in the United States today. A great many of these diseases can be cured or helped by surgical therapy. It may be stated safely that present technics will be improved, that future developments will continue, and that no abnormality of the heart and great vessels is beyond the possibility of correction by surgical operation.

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**Cost Survey on
Syringes, Needles**

(Continued From Page 80)

hospital was the smallest of the seven surveyed. It also was the only hospital that had a central supply that processed all needles and syringes used. Hospital D had the highest cost at \$0.1272 per injection. This hospital processed more than 50 per cent of its syringes and needles at the various nursing stations throughout the institution.

From the costs accumulated it was possible to calculate the costs of hypodermic size needles separate from the intramuscular sizes. In addition, the costs of the three most widely used sizes of syringes have been determined.

1. Injection cost by type of needle.

Table 3 (p. 80) shows in summary the cost of processing and using hypodermic and intramuscular needles on a per injection basis in six of the seven hospitals surveyed. (At Hospital G it was not practical to develop costs in this kind of detail.) To calculate these costs it was necessary to allocate to needles and syringes on a 50-50 basis the cost of general use raw materials.

SIZES OF NEEDLES

The needles that were considered the hypodermic sizes were 24 to 26 gauge and $\frac{1}{2}$ to $\frac{3}{4}$ inch lengths and the intramuscular sizes were 18 through 22 gauge and 1 inch to $1\frac{1}{2}$ inch in length. The costs per injection were developed for each type by dividing the direct costs by the injections that applied to each type. As Table 3 indicates, intramuscular needles cost more to use on a per injection basis than the hypodermic sizes. The cost range on hypodermic sizes was \$0.0090 to \$0.0378 with a simple average of \$0.0230. The intramuscular sizes ranged from \$0.0195 to \$0.0538 with an average of \$0.0360. Hospital A has the lowest cost for both sizes because of the low processing labor cost.

2. Injection cost by size of syringe.

Table 4 (p. 80) presents the per injection costs of the three most widely used syringes, 2 cc., 5 cc. and 10 cc. sizes. The 2 cc. size showed a cost range of \$0.0240 to \$0.0800 per injection and an average cost of \$0.0416. The cost of the 5 cc. size ranged from \$0.0392 to \$0.0811, with an average of \$0.0548. The 10 cc. syringe indicated costs ranging from \$0.0349 to \$0.0896 and averaging \$0.0571. Hospital F had the lowest costs in the processing and using of the three syringe sizes analyzed.

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NEWS DIGEST

Health Groups Urged to Mobilize Against Threat of Asian Flu . . . Management Symposiums to Be Feature of A.H.A. Convention . . . Blue Cross-Blue Shield List Contest Winners . . . West Virginia Backs Mary Schabinger for A.H.A. Office

A.M.A. and Public Health Officials Urge Prompt Action by Health Groups to Meet Asian Flu Threat

CHICAGO. — The great need is for speed on the part of medical, hospital and allied health groups in preparing to meet the threatened epidemic of Asian influenza, according to Dr. Harold C. Lueth of the American Medical Association's Council on National Defense. As head of the A.M.A. committee on influenza, which has been assigned the task of formulating methods of coping with the problem, Dr. Lueth was one of the representatives of 13 national health organizations meeting with Surgeon General Leroy E. Burney of the Public Health Service in Washington, D.C., August 13 and 14.

Action taken at the meeting included a strong recommendation that local medical societies get together with representatives of hospital, nursing and pharmacy associations, as well as such voluntary health agencies as the American Red Cross, American Cancer Society, and National Tuberculosis Association, to plan now what to do when a sizable section of the population is afflicted with the virus. The operative word, it is apparent, is *when*, not *if*. Asked if there were any chance that the epidemic would not materialize, Dr. Lueth pointed out that the seeds have already been sown and, in view of the mobility of the American public, it is reasonable to suppose they will be scattered widely and fast.

Specific problems confronting hospitals, it was explained, are likely to concern (1) selective admission of patients; (2) isolating influenza patients, and (3) keeping the hospital staffed in case of a high attack rate in any given community. As Dr. Lueth phrased it: "If the nurse gets sick, who's going to be the nurse's aide?" It is important, he added, for hospitals to see that their own employees are protected as far as possible. How this is to be accomplished, *i.e.* whether employees will be vaccinated en masse

in the hospital or sent to their individual physicians, will be for each hospital to decide.

It will also be up to the hospitals to determine whether they can or will set any limits on admissions to ensure that there will be beds available to care for seriously ill patients. Influenza victims who will need hospitalization, it was explained, would include those with complications; pregnant women, and persons suffering from lung diseases.

"Great reliance must, of necessity, be placed on home care because of the current high occupancy rate in civilian hospitals," Dr. Lueth stated in a news release. "Special problems will develop if the disease occurs in camps and at large meetings or assemblies because usually there are insufficient accommodations for providing bed care for large numbers of patients who suddenly become ill."

Dr. Lueth's committee plans, among its other activities, to explore the possibilities of "making full use of hospital facilities, such as curtailment of elective surgery, diagnostic studies, and so forth. The use of F.C.D.A. Emergency Hospital units might be required."

Although the measures necessary to deal with the epidemic will be taken at the community level, representatives at the Public Health Service meeting urged that there be continuing close cooperation between the medical and hospital associations and the Public Health Service and that lines of communication be kept open both ways.

A special meeting in Bethesda, Md., of state and territorial health officers was scheduled for August 27 and 28. At this session, it was stated, the public health officials would be brought up to date on the status of the Asian influenza virus at the time and would make recommendations regarding action to be taken by public health agencies at the local level.

West Virginia Trustees Back Mary Schabinger

WHITE SULPHUR SPRINGS, W. VA. — Members of West Virginia Hospital Association's board of trustees have endorsed Mary Schabinger for the office of president-elect of the American Hospital Association. Miss Schabinger is administrator of De Ette Harrison Detwiler Memorial Hospital, Wauseon, Ohio. The board of trustees took the action at the 32d annual meeting of the association here August 3. Approximately 125 persons attended the convention.

L. Wade Coberly, administrator of Davis Memorial Hospital, Elkins, was named president-elect of the association.

Other officers are: president, A. C. Weaver, administrator, Charleston General Hospital, Charleston; reelected vice president, Sister M. Carola, C.M.P., administrator, St. Mary's Hospital, Huntington; reelected treasurer, J. Harold Laughlin, administrator, Staats Hospital, Charleston. William R. Huff is executive secretary.

New members of the board of trustees are: George W. Holman, administrator, Union Protestant Hospital, Clarksburg; James L. Foster, administrator, Bluefield Sanitarium, Bluefield, and D. M. Gould, superintendent, Logan General Hospital, Logan.

Hospital Given \$10 Million

NEW YORK. — Roosevelt Hospital will eventually receive more than \$10 million from the estate of Garrard Bigelow Winston, the hospital's former president and undersecretary of the U.S. Treasury in the Coolidge Administration. It was requested, but not demanded, that the money be used for construction; the hospital's board of trustees will make the final decision on use of the fund, John Nicklas, assistant vice president of Roosevelt, said. Part of the estate was left to Mr. Winston's sister and will be given to the hospital after her death.



Foyer of Lutheran Hospital, St. Louis, Missouri, showing ceiling installation of Acousti-Celotex Celotone® Fissured Mineral Fiber Tile and Striatone® Striated Mineral Fiber Tile (both incombustible). Architect: Froese, Maack & Becker. Acousti-Celotex Contractor: Henges Company, Inc.

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A.H.A. Will Introduce Daily Management Symposiums at the 59th Annual Meeting

CHICAGO. — New features to be introduced at the 59th annual meeting of the American Hospital Association in Atlantic City, N.J., September 30 to October 3 will include national speakers at the general assemblies, management symposiums, and brief discussions of successful hospital activities, under the heading, "It Worked for Us."

The first general assembly, on Monday afternoon, will concern "Education and the Nation," with Carter Davidson, president of Union College, Schenectady, N.Y., as the speaker. The management symposium will be "Executive Behavior in an Organization"; Kenneth McFarland, educational consultant and lecturer for General Motors Corp., Topeka, Kan., will speak on "Management and the Executive." At all the management symposiums, a panel of hospital administrators will discuss the speaker's remarks following his presentation.

On Tuesday afternoon, Dr. Julian P. Price, trustee of the American Medical Association and chairman of the board of commissioners of the Joint Commission on Accreditation, will discuss "The Nation's Health" at the general assembly. Management symposium speaker that day will be David G. Moore, professor of management, College of Business and Public Service, Michigan State University, who will talk on "Effective Leadership Through People," under the general theme of "The Human Equation in Management."

"Living in Today's World" will be the theme of Dr. Ralph W. Sockman, minister of Christ Church Methodist, New York, and National Radio Pulpit, at Wednesday's general assembly. At the afternoon session, Rep. John E. Fogarty of Rhode Island will discuss "Voluntary Health Care and the Government."

W. Allen Wallis, dean of the school of business and professor of statistics and economics at the University of Chicago, will be the featured speaker at the Wednesday management symposium. He will speak on "Statistics as a Tool of Management," as part of the general theme of "New Concepts and Technics of Administration."

The final general assembly, on Thursday morning, will be addressed by Basil O'Connor, president of the National Foundation for Infantile

Paralysis, Inc. He will discuss "The Future of Hospitals."

Thursday's management symposium will continue the general theme of Monday's session, "Executive Behavior in an Organization." Richard D. Vanderwarker, vice president and general manager of Memorial Center for Cancer and Allied Diseases, New York, will discuss "Decision-Making."

Round table sessions will be held each afternoon and will include accreditation, auxiliaries, Blue Cross, housekeeping, dietary, nursing, pharmacy, volunteers, trustees and state associations. Other topics will be taxation, prepayment plans, personnel, social medicine, public relations, physical therapy, accounting, financing, purchasing, chronic care, professional practice, radioisotopes, safety and disaster planning.

Elmore Petersen to Give Annual Bachmeyer Lecture

CHICAGO. — The Bachmeyer Lecture of the American College of Hospital Administrators will be delivered by Elmore Petersen, dean emeritus of the school of business, University of Colorado, it has been announced. His topic will be "A Practical Philosophy of Administration." The address will be given at the annual banquet on Sunday, September 29, in Atlantic City, N.J., during the group's 23d convention.

Mr. Petersen, who has lectured widely on hospital administration topics, was on the faculty at the University of Colorado for 38 years and has co-authored several books on business management.

Joins University Group

CLEVELAND.—Benjamin Rose Hospital, specializing in geriatric care, officially joined University Hospitals here August 1. Under the new arrangement, medical care at Benjamin Rose will become the responsibility of the medical council of University Hospitals. Stanley A. Ferguson, director of University Hospitals, will be responsible for the general operation of the hospital. Marion L. Bitman will remain as administrative director of Benjamin Rose.

Blue Cross-Blue Shield Groups Win Trophies in Public Relations Contest

CHICAGO.—Michigan Hospital Service-Michigan Medical Service, Detroit, has been named winner of the 1957 annual Blue Cross and Blue Shield National Public Relations contest, for excellence of achievement in all around public relations among Plans with more than 500,000 members.

The Hospital Service Plan of Lehigh Valley, Allentown, Pa., won in the 200,000-500,000 members class.

For the first time, two Plans tied for a first place in one category. Named first place winners in the less than 200,000 members class were Associated Hospital Service of Arizona-Arizona Blue Shield Medical Service, Phoenix, and Intermountain Hospital Service-Medical Service Bureau of the Utah State Medical Association, Inc., Salt Lake City.

Receiving honorable mentions in the over-all public relations competition were Associated Hospital Service of Philadelphia, Illinois Hospital Service, Chicago, and Hospital Service Association of Toledo.

First place awards for excellence in specific areas went to:

Subscriber relations, Capital Hospital Service, Harrisburg, Pa.; *community relations*, Associated Hospital Service of Arizona-Arizona Blue Shield Medical Service; *enrollment promotion*, California Physician's Service, San Francisco.

Hospital and physician relations, Rochester Hospital Service Corporation-Genesee Valley Medical Care, Inc., Rochester, N.Y.; *annual reports*, Intermountain Hospital Service-Medical Service Bureau of the Utah State Medical Association, Inc., and *employee publications*, Associated Hospital Service of Arizona-Arizona Blue Shield Medical Service.

Associated Hospital Service, Inc., Milwaukee-Surgical Care, Milwaukee County, Milwaukee, won three of nine honorable mentions.

The others were given to Blue Cross Hospital Plan, Inc.-Kentucky Physicians Mutual, Inc., Louisville, Ky.; Intermountain Hospital Service-Medical Service Bureau of Utah; Quebec Hospital Service Association, Montreal; Wyoming Hospital Service-Wyoming Medical Service, Cheyenne; Hospital Service of Southern California, Los Angeles, and Hospital Savings Association of North Carolina, Chapel Hill.

"Nobody talks about it"...

but

is the incidence of cross infection getting to be a problem in your hospital — despite stringent aseptic technics?



Because of the basic nature of hospital service, keeping cross infection to a minimum has always been a difficult task. With antibiotics or other systemic antibacterials controlling the primary infection in most patients, reducing cross contamination may well depend upon making the total hospital environment as aseptic as possible. This, of course, is far from a new idea—but the prevalence of highly virulent, antibiotic-resistant organisms has accentuated the need for increased vigilance and control. Every hospital and physician knows the havoc that can be created by cross infection with antibiotic-resistant streptococci and staphylococci.

Whether infections are caused by contact with contaminated surfaces or objects, by breathing in dust containing viable organisms, or by contaminated dust settling on wounds—critical evaluation of both disinfection procedures and the disinfectant used may help solve the problem. For instance, regular mopping of all floors with a good disinfectant can remove the source of stirred-up contaminated dust.

How good does a disinfectant have to be?

It should approach the "ideal" as closely as possible. Most frequently mentioned requirements for the ideal disinfectant are that it be: microbicidal rather than inhibitory in use dilutions; not poisonous or irritating; rapid in action against a wide range of organisms; active in the presence of extraneous organic matter; not corrosive or staining; soluble in water; effective at ordinary temperatures; a good wetting agent; inexpensive; and stable for long periods of time.

Why is it important for a disinfectant to kill a wide range of organisms?

By definition, a disinfectant is a chemical substance which destroys all common pathogenic organisms. Some so-called disinfectants which do not kill all the commonly harmful microorganisms, including tubercle bacilli, are not actually fulfilling their purpose. For

example, pine oil compounds are ineffective against staphylococci, while quaternary ammonium compounds are inactive against tubercle bacilli or pathogenic fungi. Enteric pathogens transmitted primarily by contact, respiratory pathogens spread by inhalation of contaminated dust, and fungi, such as those causing athlete's foot, can be destroyed at the same time using Lysol,* O-syl,* or Amphyl.* They are all-purpose, broad-spectrum phenolic type disinfectants.

Is tuberculocidal action necessary?

With 400,000 active TB cases in the United States today, and 100,000 new ones being reported each year, preventing the spread of tuberculosis is still a problem. Tubercle bacilli can live for weeks on inanimate surfaces and be stirred into the air and then inhaled. To control this source of infection, the disinfectant must penetrate the waxy covering of the tubercle bacillus and kill it. Lysol, O-syl, and Amphyl are all tuberculocidal and are recommended for concurrent and terminal disinfection of all premises occupied by tubercular patients. Tuberculocidal action is important for disinfection of thermometers as well as of instruments used to examine body cavities since these may touch unrecognized sources of tubercular infection.

Does the presence of organic matter affect the efficiency of the disinfectant?

It depends on the type of disinfectant. With Lehn & Fink disinfectants, which are synthetic phenolics, bactericidal, fungicidal and tuberculocidal efficiency is retained. Dilutions recommended for various applications of Lysol, O-syl, and Amphyl are for use in the presence of organic matter.

Is standardizing on one disinfectant of any advantage to the hospital?

Besides the extra assurance of knowing that the same efficient disinfectant is being used throughout the hospital, there is a financial saving possible through volume discounts.

Do Lysol, O-syl, and Amphyl do the same disinfecting job?

Any one of them kills bacteria, fungi, and TB bacilli efficiently, but each has individual characteristics.

Lysol was far ahead of its time when introduced over fifty years ago. Recently the formula was improved; the odor was lightened and toxicity was reduced so that the "poison" label is no longer needed. Many hospitals prefer Lysol because of its long reputation for dependability. The characteristic odor is preferred by many for psychological reasons or as an indication that disinfection with Lysol has just been done.

O-syl is preferred by hospitals wanting all the germicidal efficiency of Lysol but without the odor. It is practically odorless when diluted for use. Like Lysol, O-syl is highly concentrated. Only a 1% solution of either (1 part to 100 of water) is needed for most applications.

Amphyl is also odorless when diluted for use. Convenience and low cost due to its high concentration often make Amphyl the disinfectant of choice. Amphyl is twice as powerful as Lysol or O-syl but does not cost twice as much. A ½% solution (1 part in 200 of water) is sufficient for general disinfection so that the cost per gallon of "use dilution" is less than with Lysol or O-syl. When expected contamination is great, as in TB or isolation wards, Amphyl is often preferred.

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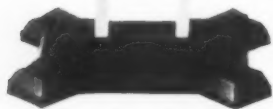
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Nonprofit Short-Term Hospitals' Costs per Day Rise 149 per Cent in 11 Years

CHICAGO.—Costs per patient day in nonprofit short-term hospitals rose 149 per cent in the 11 year period from 1946 through 1956, according to the Administrators' Guide of the American Hospital Association published last month.

In 1956 this group of hospitals spent \$24.99 per day to care for each patient, as compared to \$10.04 in 1946. The rise from the 1955 level of \$24.15 was a little more than 3 per cent.

However, the cost to the nonprofit short-term hospitals for the average patient stay rose less than the cost per patient day, because of the reduction in length of stay. From 1946 to 1956, the average cost to the hospital per patient stay rose from \$88.35 to \$187.43, an increase of 112 per cent as compared with the 149 per cent increase in expense per patient day.

Since length of stay (7.5 days) was unchanged from 1955 to 1956 in short-term nonprofit hospitals, the increase in cost both per day and per stay from 1955 to 1956 was about 3 per cent, the report stated.

Admissions to hospitals of all types in 1956 were 132 per thousand population, or a total of 22,089,719. In 1946 the rate was 112 per thousand population. If the ratio of admissions to population had remained at the 1946 level, there would have been only 19 million admissions in 1956, the Guide reported.

Over the 11 year period, the number of admissions climbed 41 per cent, and from 1955 to 1956, nearly 5 per cent.

Fifty-one per cent of the 6966 hospitals in the continental United States are nonprofit, according to statistics compiled by the association; 17 per cent are proprietary, 6 per cent are federal, and 26 per cent are state and local governmental hospitals. The 6966 hospitals had 1,607,692 beds, and an average daily census of 1,355,792 in 1956.

The voluntary nonprofit hospitals led in number of admissions—nearly 15 million persons in 1956. More than 4 million admissions were to state and local governmental hospitals. Proprietary and federal hospitals each recorded about 1.5 million admissions.

Of the average 1,355,792 patients in hospitals on any given day in 1956, 62 per cent were in state and local governmental hospitals, 24 per cent in

nonprofit hospitals, 12 per cent in federal hospitals, and 2 per cent in proprietary hospitals.

A high proportion of psychiatric and tuberculosis institutions providing mainly long-term care accounted for the large percentage of patients in governmental hospitals each day. Although less than 2 per cent of all admissions in 1956 were to psychiatric hospitals, 53 per cent of all patients in hospitals on any given day were in psychiatric institutions.

The number of hospital births in 1956 was 3,491,141, an increase of 64 per cent over 1946, but only 1 per cent above the 1955 total. Nearly 72 per cent of the total hospital births in 1956 were in short-term nonprofit hospitals, while 18 per cent were in nonfederal governmental hospitals, almost 6 per cent in proprietary hospitals, and 4.5 per cent in federal hospitals, the association reported.

Oregon Legislature Lets Hospitals Keep Immunity

PORTLAND, ORE.—A bill sponsored by the Oregon State Bar Association to eliminate the immunity defense in actions against charitable hospitals died in the senate judiciary committee of the Oregon legislature when it adjourned recently, it was reported in the August issue of *Washington Hospitals*.

James G. Swindells, attorney for the Oregon Association of Hospitals, commented:

"Those urging passage of the bill used as an argument that the (state) supreme court in its last decision held that the rule of charitable immunity was of such long standing it had now become public policy and that it was up to the legislature to change this long-standing rule of our supreme court.

"It might now be argued that the refusal of the legislature to change the rule would render the doctrine permanent and secure against judicial attack in the future. Such an interpretation, however, may not be well founded."

Mr. Swindells noted that the State Court of Appeals in New York recently upset the immunity defense of charitable hospitals, even though that state always had held to the immunity rule.

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with a new degree of freedom from side effects

Harmonyl makes rauwolfia more useful in your everyday practice. Two years of clinical evaluation have shown this new alkaloid exhibits significantly fewer and milder side effects than reserpine. Yet Harmonyl compares to the most potent forms of rauwolfia in effectiveness.

Most significant: Harmonyl causes less mental and physical depression—and far less of the lethargy seen with many rauwolfia preparations.

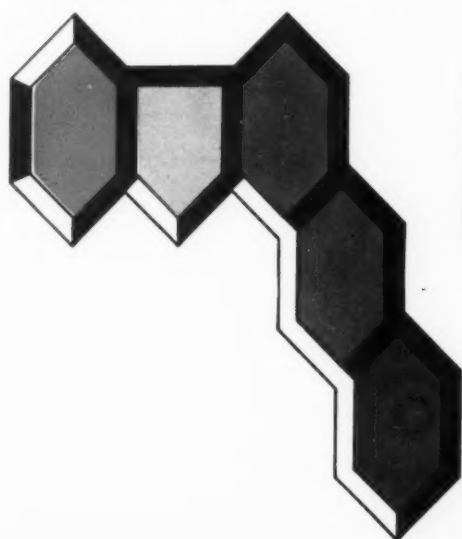
Patients became more lucid and alert, for example, in a study¹ of chronically ill, agitated senile cases treated with Harmonyl. And these patients were completely free from side effects—although a similar group on reserpine developed such symptoms as anorexia, headache, bizarre dreams, shakes, nausea.

Harmonyl has also demonstrated its potency

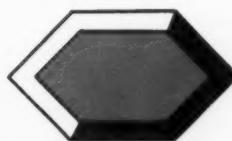
and relative freedom from side effects in hypertension. In a study comparing various forms of rauwolfia,² the investigators reported deserpidine “an effective agent in reducing the blood pressure of the hypertensive patient both in the mild to moderate, as well as the severe form of hypertension.” They also noted that side reactions were “less annoying and somewhat less frequent” with this new alkaloid. Other studies confirm that few cases of giddiness, vertigo or sense of detached existence or disturbed sleep are seen with Harmonyl.

Professional literature with complete information on this unique new rauwolfia derivative is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg. (grooved) and 1-mg. (grooved) tablets.

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References: 1. Communication to Abbott Laboratories, 1956. 2. Moyer, J. H., et al.: Deserpidine for the Treatment of Hypertension, *Southern Medical J.*, 50:499, April, 1957.



* Trademark for Deserpidine, Abbott

Administrators of Small Hospitals Read, Talk, Study in New Course at Columbia

NEW YORK. — The administrators of 41 small hospitals have completed the first two weeks in residence of Columbia University's new continuation education course in basic hospital administration and are at work on a series of monthly assignments.

Beginning on June 10, the first class in the new course met for two weeks on the campus of the school of public health and administrative medicine, under the direction of Harold Baumgarten Jr.

This was the first of three parts of a year's intensive study. The campus session will be followed by 11 months of home study, during which each administrator will complete 11 exercises comprised of reading assignments and questions. Next June the class will return to the campus for two weeks.

All the students are administrators of hospitals or related institutions of 100 beds or less, located within the membership area of the New England and Middle Atlantic Hospital assemblies. None had previous academic preparation in hospital administration, although most had attended institutes.

Even though most of the administrators have been out of school for about 15 years, they found the intensive classwork and seminar sessions of great interest and had no difficulty adjusting to school routine.

"We're back in school and we love it!" was the reaction of the class, despite the 90° F. temperatures that scorched New York during their stay on campus.

Dr. Ray E. Trussell, executive officer of the school, commented:

"This is the hardest working and most realistic group of students I have ever seen. These people are here for a purpose, and are willing to work to achieve that purpose. The faculty of the school is very pleased with this class and we are glad to have them here."

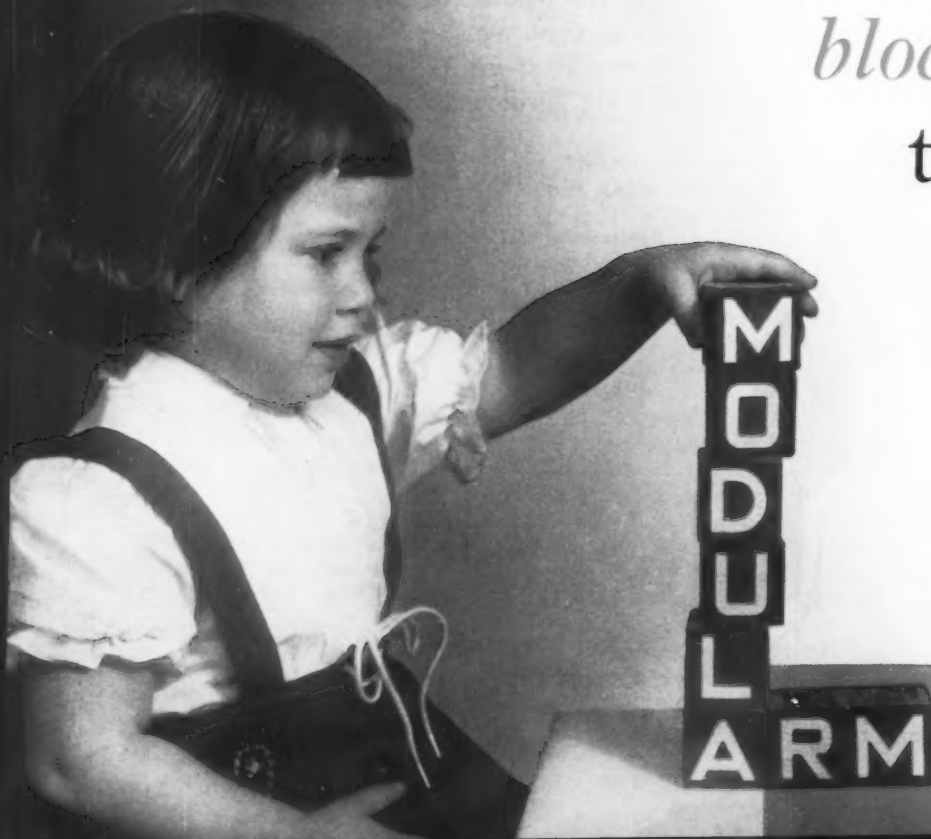
Dr. Anthony J. J. Rourke, hospital consultant, New Rochelle, N.Y., said, "I enjoyed every minute with this group. It is willing to work and keeps each faculty person on his toes"—a view reflected by all of the faculty members who participated in the teaching of the class.

Before the two-week session was over, the administrators had elected officers and regional leaders to plan regional study meetings during the 11 month home study period, as well as after completion of the course.

President of the class is Edward C. Linn, administrator of Aliquippa Hospital, Aliquippa, Pa. The secretary is Dorothy Abrahams, administrator of Mount Eden General Hospital, Bronx, N.Y. Regional leaders are Sister M. Augustine, Little Company of Mary Hospital, East Cambridge, Mass.; Bernard Ginsberg, administrator of Liberty Maimonides Hospital, Liberty, N.Y.; Maj. Elsie C. Van Pelt, superintendent of Booth Memorial Hospital, Buffalo, N.Y., and Salvatore Alvin, administrator of Belvedere General Hospital, Pittsburgh.

Since group action is essential to the hospital administrator's life, study was carried on primarily in this way. The principles of "group action" were introduced at the start of the session, so the students could relate these principles to their own work early in the period. The group was divided into three committees, and each acted to solve problems or prepare material for presentation to the entire class.

*Building
blocks
that spell a*



September 30 thru October 3—
American Hospital Association
59th Annual Convention—At-
lantic City, New Jersey—Booth
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For each assignment, members of the class were designated as discussion leader, observer or recorder. In this way, each student assumed specific responsibility for the group action at least once during the on-campus period. This was considered an extremely valuable experience by the students.

The course began with a study of administration, and the application of the concepts and processes of administration to hospitals. Dr. E. Dwight Barnett, director of Columbia's academic course in hospital administration, conducted several classes on the subject of hospital organization. Committees of the class had a busy time designing and describing a 75 bed hospital. Much of one day was spent on the matter of the medical staff.

Trustees and relationships with trustees was the next topic. J. Harold Johnston, executive secretary of the New Jersey Hospital Association, and Henry Lyman, formerly president of the Middlesex Hospital, Middletown, Conn., gave the students a review of this subject.

Matters of finance and accounting were handled for the students by such persons as Charles Roswell of the

United Hospital Fund, New York; Nelson Henson, administrator, Englewood Hospital, Englewood, N.J., and David Walsh, controller, Memorial Center for Cancer and Allied Diseases, New York.

Much of the second week was devoted to the place of the hospital in the community, with discussion of "The Mission of the Community Hospital," "The Hospital's Responsibility for Medical Care in the Community," and "The Relationships Between the Hospital and Other Community Health Agencies." Among the faculty for this part of the course were Sister Loretto Bernard, Dr. Rourke, and Dr. Trussell.

There were two sessions on purchasing, and an exploration of the hospital's legal responsibilities for the quality of patient care, the latter subject presented by Joseph Terenzio, administrator of Knickerbocker Hospital, New York.

The last two days were devoted to the subject of personnel. Harvey Schoenfeld, administrator, Barnert Memorial Hospital, Paterson, N.J., discussed "What Are the Mechanics of the Personnel Function?"

During the 11 month home study period, the students will work with a

carefully selected group of preceptors, thus giving them an opportunity to observe and work with successful administrators in their areas. This will also help foster better working relationships between the larger hospitals, with their extensive resources, and the smaller hospitals in the various areas, a university report stated. The 31 preceptors were invited to serve the course upon recommendation of the faculty of the school. "It is a tribute to the motivation for self-improvement in the hospital field that not a single administrator who was asked to serve as a preceptor refused," continued the report.

The content of the home study exercises covers the various departments in a general hospital, to give each student a clear picture of the functions of each department and the various ways these functions may be accomplished. To supplement textbook reading assignments, students will be supplied with related materials, reprinted from current hospital literature, which have been evaluated by a faculty committee. Thus, at the end of the home study period, each class member will have a comprehensive

(Continued on Page 157)

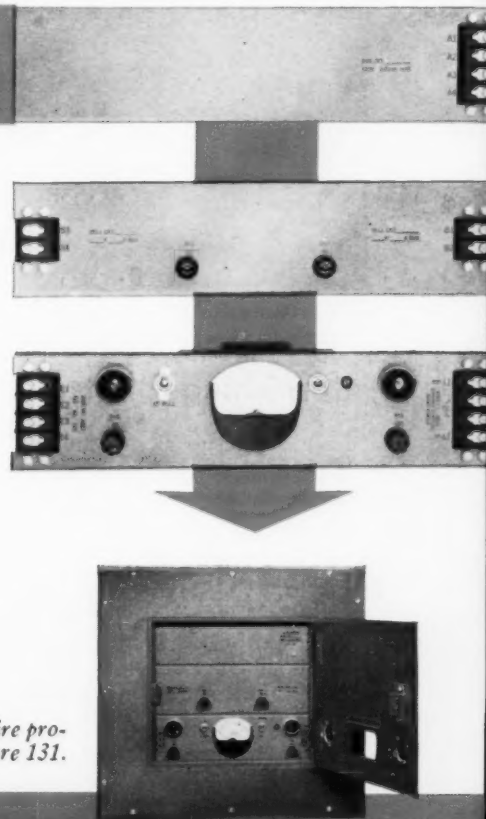
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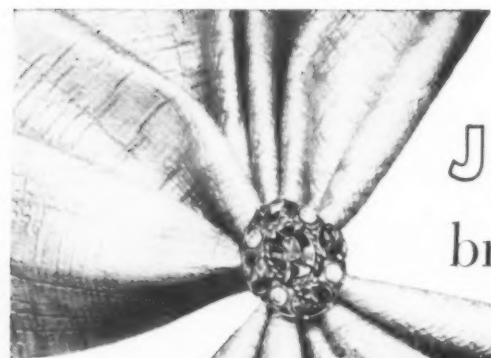


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BETTER THINGS FOR BETTER LIVING
...THROUGH CHEMISTRY

Vol. 89, No. 3, September 1957

(Continued From Page 155)

library of material on the structure and functions of departments.

The final two weeks on the campus next June will be devoted to a study of the operation of the hospital. Problems administrators face daily in the fields of finance, medical staff relations, organization, and public or community relations will be examined thoroughly.

The program of continuation education is an additional and, in some respects, new type of education in the field of hospital administration, according to university officials. Columbia University began the program with funds from the Kellogg Foundation, which are supplemented by a modest tuition charge. The objective of the course is to give administrators of smaller hospitals (currently, 100 beds or less), who have had little or no academic work in hospital administration, an opportunity to study hospital organization and management. The program is not designed to recruit persons to become administrators, but rather to help those who are now administrators; admission, therefore, is restricted to persons holding the title of administrator or its equivalent in the hospital.

Preparation for the program took almost a year. The faculty called upon experienced administrators and executives from the field for advice and assistance. Executive personnel of the state and regional hospital associations in the area served by the program were consulted on structure and presentation. A policy advisory committee aided in planning the scope and content of the program, and there has been continuous liaison with these executives on matters of student recruitment and selection.

WRONG HOSPITAL

CHICAGO.—The system of charges under which doctors' contributions to the hospital fund raising campaign are collected, as described by Dr. Frederic S. Ewens of Manhattan Beach, Calif., and reported on page 50 of *THE MODERN HOSPITAL* for July 1957, is in use at the Torrance Memorial Hospital, Torrance, Calif., and not at the Santa Monica Hospital, Santa Monica, Calif., as erroneously stated in the article.

Dr. Ewens is in no way connected with the staff of Santa Monica Hospital, he has indicated.

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"Specialists in Commercial Food Waste Disposers for over 10 Years"

County Supervisors Dismiss Five Trustees of Ironwood Hospital

IRONWOOD, MICH.—Following several months of investigation into operations of the Grand View Hospital here, the Gogebic County Board of Supervisors last month met in a special session on hospital problems and voted to remove five members of the hospital board of trustees from office, effective at once.

The investigation resulted from widespread dissatisfaction with the way hospital affairs have been managed by the board since the state supreme court upheld a 1952 circuit court ruling stipulating that hospital patients have an "absolute right" to employ their own physicians and that such physicians have exclusive charge of the care and treatment of such patients—a ruling that was interpreted as giving physicians complete authority over nurses, laboratory technicians, and other hospital employees.

By a 19 to 4 vote at the special session, the board of supervisors found that five members of the seven-member hospital board were "incompetent to execute properly the duties of their offices" as board members. The resolution named the five members who were removed from office, but the board did not announce the reasons these members were dismissed and the other two members retained.

Walter F. Olson, chairman of the board of supervisors, said the hospital had suffered "professionally and economically" and added that its financial affairs were in such shape that the hospital would become a burden on taxpayers if finances were not improved.

There were no personal animosities involved in removal from office of the five trustees, Mr. Olson said.

New Tri-State Assembly Officers Are Elected

CHICAGO.—Dr. A. C. Kerlikowske, director of University Hospital, Ann Arbor, Mich., has been named president of the Tri-State Hospital Assembly.

Named vice president was Sister Mary Reginald, R.S.M., assistant director of hospitals (Detroit Province), Sisters of Mercy, Dyer, Ind.; secretary, Leon C. Pullen Jr., administrator of Decatur and Macon County Hospital, Decatur, Ill.; treasurer (reelected), Riley McDavid, administrator, Kenosha Hospital, Kenosha, Wis.

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—a move that promises better
service to all !

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By combining research and manufacturing facilities, Canco and Dixie Cup will be able to devise even better, more convenient products. By uniting management and marketing staffs, these two corporations will be able to offer more efficient, more complete sales and technical service.

In the months and years to come, you can fully expect that *your* industry, and those it serves, will benefit from this merger !



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"Our hospital was increased in size from 63 beds to 140 beds, but towel costs did not increase because we changed to Turn-Towel service."

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Fire Safety Expert Says Nursing Homes Are Unsafe

LOS ANGELES.—Nursing homes head the list of unsafe places to live, a fire safety expert told the 61st annual convention of the National Fire Protection Association here recently.

"During the last 10 years, 283 lives have been lost in the 15 most notable nursing home fires," Chester I. Babcock, manager of the association's fire record department said.

Mr. Babcock called Georgia, Louisiana, California and the city of Lexington, Ky., "exceptions to the national pattern" in fire safety regulation of nursing homes. These areas, he said, are setting examples of what can be done to provide safe places to live. He added that none have been represented in the list of recent nursing home fires.

Howard W. Naulty, a member of the association's subcommittee on nursing homes and a nursing home operator, suggested that funds now earmarked for hospitals could be diverted to building nursing homes at a lower cost per bed.

200 Costa Ricans Attend Second Hospital Congress

SAN JOSE, COSTA RICA.—More than 200 persons met here June 21 and 22 for the Second Costa Rican Hospital Congress to hear speakers discuss planning and organization of a hospital, organization of medical staff and nursing services, and centralization of services. Gordon A. Friesen, hospital consultant to the Costa Rican government, discussed hospital planning. Operations of a central laundry and a central pharmacy, as well as a national pharmacy and therapeutics committee, were explained to the administrators, doctors, nurses and representatives of the paramedical professions.

During the congress, the Costa Rican Hospital Association was formed, with preliminary approval of the statutes and election of officers.

Officers in Indianapolis

INDIANAPOLIS.—Recently elected officers of the Hospital Council of the Indianapolis Area are: president, Robert W. Carithers, assistant administrator, Methodist Hospital; vice president, Elton T. Ridley, assistant administrator, Indiana University Medical Center, and secretary-treasurer, Richard P. Condelaro, controller, Community Hospital.

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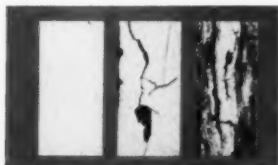
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Flexalum wipe-clean plastic tapes have no loose fibers, no porous openings to absorb dirt or bacteria. And they won't fade, fray, shrink or stretch. Spring-tempered aluminum slats have exclusive baked-enamel finish with permanent hard wax surface that's easier to keep clean.



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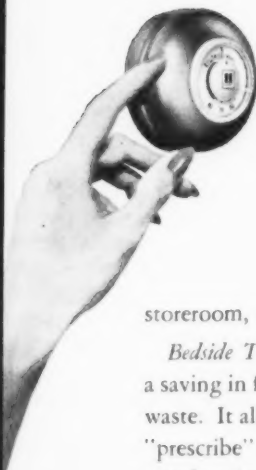
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Saves steps for busy nurses • Provides better therapy

More comfort for your patients



HONEYWELL *Bedside Temperature Control* gives your patients finger-tip adjustment of their own personal comfort. It frees your nurses from "chambermaid chores" such as opening and closing windows, carrying blankets from the storeroom, and refilling hot-water bottles.

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installation, the beautiful new Honeywell Round thermostat is mounted for finger-tip adjustment by the patient. In 2-bed rooms it is mounted between the beds where temperature can be adjusted by either patient.

Specify Honeywell *Bedside Temperature Control* for your new hospital or addition. Also available for your existing bedrooms at costs as low as \$87.50 per room*. No tearing out of walls or redecorating is necessary. For more information, call your local Honeywell office now. Or write Honeywell, Dept. MH-9-26, 2727 4th Avenue, South, Minneapolis 8, Minnesota.

*Average installed price for room with one radiator

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Hospital Room Temperature Controls

Hospital Personnel Across the Country Gets Practice in Technics of Fire Fighting

CHICAGO.—The fire fighting technics of Lt. Robert McGrath of the Chicago Fire Prevention Bureau have been put to use several times during the last two months, reports show.

At Walther Memorial Hospital, Chicago, nurses recently completed a fire prevention and firefighting course taught by Lieutenant McGrath. A few weeks later fire broke out in a sixth floor lounge closet, and nurses came running with fire extinguishers. They

were able to put out the blaze by planned and practiced technics without disturbing any patients.

At Letterman Army Hospital, San Francisco, nurses and orderlies rescued three patients and extinguished 10 fires in less than one minute, according to the *San Francisco Examiner*. This situation, however, was a demonstration of new methods for evacuating hospital patients in case of fire, earthquake or other natural disaster.



Student nurse shows hospital personnel at San Joaquin General, Stockton, Calif., why water based extinguisher should never be used in fighting any type of flammable liquid fire.

Recent campaign for

Bethesda Hospital, Hornell, N. Y.

ALMOST 50% OVERSUBSCRIBED!

Goal: \$325,000. Raised to Date: \$475,000

For a fund-raising campaign to be successful it must, of course, reach or exceed its financial objective. In the recently completed campaign directed by this firm for the Bethesda Hospital, the oversubscription totaled almost half the original goal. This fact speaks for itself.

In reviewing a completed fund-raising drive, however, it is also important to consider the attitudes and reactions of those who participated in the appeal. In this respect the Bethesda campaign can be rated as wholly successful. As Mr. Allen P. Loohn, President of the Bethesda Board of Directors, stated in a recent letter, "... the outcome of our campaign has produced many more friends for Bethesda Hospital and a better understanding of our problems."

If your hospital is presently contemplating an appeal for funds and it is your intention not only to raise money but also to build understanding and friendship for your institution...the fund-raising techniques developed by this firm during the past 51 years can be as valuable to you as they were to the Bethesda Hospital.



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The emergency removal system was developed by Lt. McGrath and presented to a group of armed services nurses by Col. Isabelle Mason, educational coordinator at Letterman Hospital. Several Korean army nurses also attended.

A U.S. army spokesman was quoted as saying that Letterman would like to see all 7000 of the nation's hospitals adopt the system.

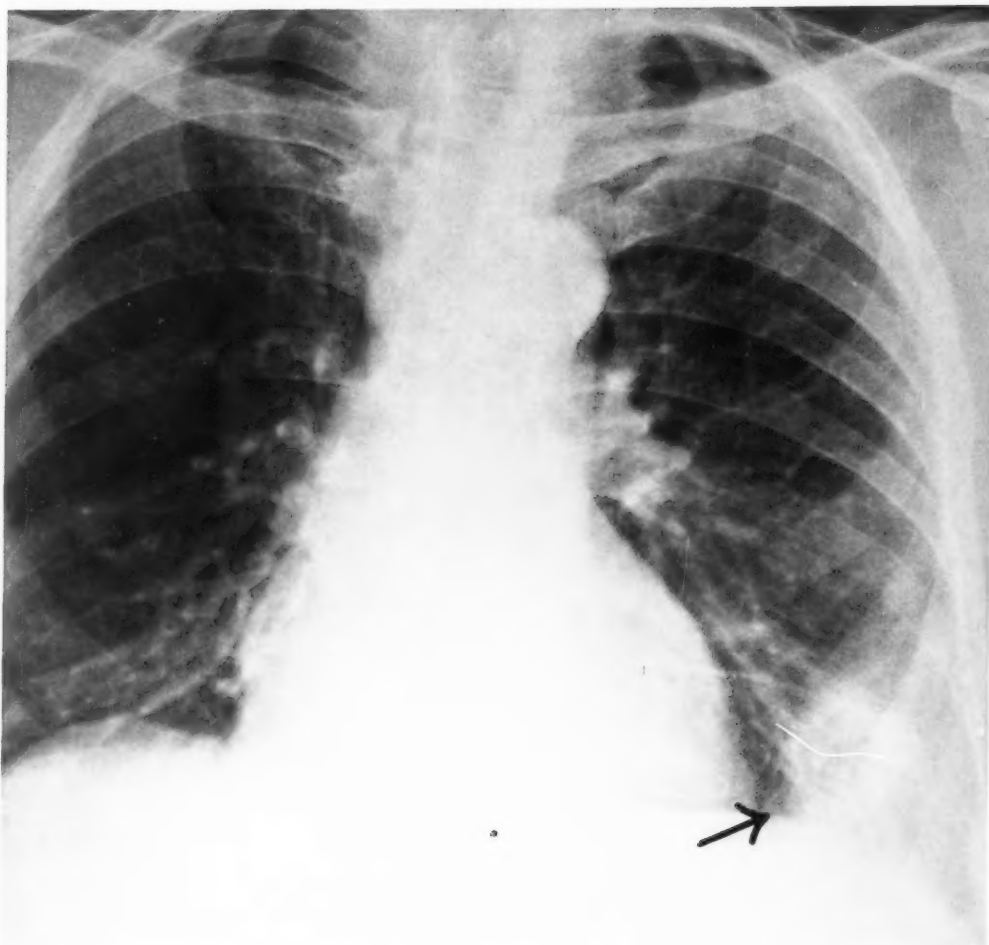
At Stockton, Calif., San Joaquin General Hospital sponsored a three-day fire safety institute in July as part of its inservice educational program. Various safety groups and fire departments cooperated in the institute.

The first day was devoted to a program for hospital personnel, and the next two days were planned for visitors as well as hospital employees. Thirty-three hospitals and agencies were represented, and the total attendance was 360 persons. Personnel from two Nevada hospitals attended the institute.

Lt. McGrath will conduct three one-day institutes in Concord and Hanover, N.H., Sept. 17 to 19, under the sponsorship of the New Hampshire Hospital Association. Hospital and nursing home personnel, as well as fire department employees, in New Hampshire, Maine and Vermont have been invited.

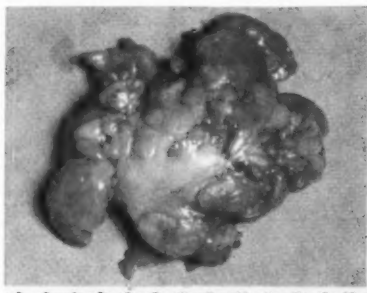
Record Consultants Meet

CHICAGO.—Stephen S. Henkin has been appointed president of the recently incorporated Association of Medical Record Consultants. Adaline C. Hayden is secretary-treasurer. Directors are Dr. Edward T. Thompson, Helen Culian, and Enna C. Black. Plans are under way for a fall meeting of the incorporators and charter members of the association, Mrs. Hayden announced.



EXCISION OF LIPOMA OF PARIETAL PLEURA: 1. Preoperative radiograph, A-P view, indicates presence of mass within pleural cavity.

*Thousands can study this case...over and over again...
...thanks to the radiographs and photographs shown here*



2. Excised Mass. Turn page for reproduction of laminagraph which locates the mass, together with color photographs of surgery.

It turned out to be a lipoma attached to the parietal pleura.

Here you see illustrated what radiologist, attending physician and surgeon saw . . . the radiographs which pin-pointed the mass, helped guide the surgeon's fingers when he removed it . . . plus photographs of the actual surgery.

With this material, physicians can review this case, use it in teaching, or research, or to illustrate a medical paper, a lecture or a scientific exhibit.

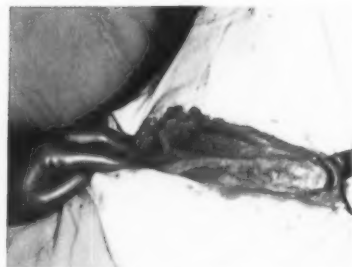
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3. Laminagraph establishes position of mass in chest. It also suggests its physical characteristics.



4. Left thoracotomy. Eighth rib is exposed.



5. Mass attached to left parietal pleura is exposed.



6. Photomicrograph of mass—a lipoma or fatty, benign neoplasm. (Magnification, X40.)



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Business Firms Lack Fixed Policy for the Support of National Health Agencies

NEW YORK. — Nearly all national business firms support national health agencies through direct contributions or United Funds and Community Chests, but few corporations have a fixed policy to determine what agencies to support or how much to give, a study by the National Better Business Bureau has found.

Fifty-four per cent of those companies replying to the questionnaire who make direct contributions to national health agencies stated that the "effectiveness of the agency's over-all program" was the chief reason for support of a particular agency.

The personal interest of a company executive was cited by 27 per cent of the respondents as the reason for supporting a specific group. In fact, 63 of the 158 respondents said that the interest of executives was responsible for their company's support of any health agency at all. About three out of four, however, said the "relation of the cause to the need of society" was the principal reason for contributing to agencies in general.

Other findings of the survey, conducted in cooperation with 26 national health agencies, were:

1. The number of national health agencies to which the average company contributes has doubled in the last five years.

2. Few companies earmark their contributions to an agency for any specific purpose.

Says Cobalt Machines Need Experienced Therapists

QUEBEC, CAN. — Installation of super-voltage cobalt therapy machines, where experienced radiation therapists are not available to direct their use, is a recent trend that should be condemned, according to a Chicago physician.

"Special experience is required for those who operate such devices. Much harm can be done by placing them in the hands of the inadequately trained," Dr. J. W. J. Carpender warned during a symposium on rotational radiation therapy at the 39th annual meeting of the American Radium Society held here this summer.

Other speakers at the meeting discussed current efforts to control and cure cancer.

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COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Atlantic City, N.J., Sept. 28-30.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Regional Membership Conference: Region 9, Chicago, Nov. 11-15. Institutes: 25th Chicago, University of Chicago, Sept. 3-13; 8th Chicago, Advanced, University of Chicago, Sept. 9-13.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 28.

AMERICAN DIETETIC ASSOCIATION, Dinner Key Auditorium, Miami, Fla., Oct. 22-25.

AMERICAN HOSPITAL ASSOCIATION, national convention, Convention Hall, Atlantic City, N.J., Sept. 30-Oct. 3.

AMERICAN HOSPITAL ASSOCIATION INSTITUTES: Staffing Departments of Nursing, Sheraton-McAlpin Hotel, New York, Sept. 23-26; Operating Room Administration, Hotel President, Kansas City, Mo., Oct. 7-10; Insurance for Hospitals, Hotel Statler, Hartford, Conn., Oct. 9, 10. Medical Record Procedures Review for Department Personnel and Administrators, Hilton Hotel, Albuquerque, N.M., Oct. 21-23; Evening and Night Service Administration, Mission Inn, Riverside, Calif., Oct. 28-Nov. 1.

AMERICAN NURSING HOME ASSOCIATION, Ambassador Hotel, Atlantic City, N.J., Oct. 7-10.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 15-18.

CALIFORNIA HOSPITAL ASSOCIATION, Lafayette Hotel, Long Beach, Oct. 30-Nov. 1.

COLORADO HOSPITAL ASSOCIATION, Hotel Denver, Glenwood Springs, Oct. 10, 11.

CONNECTICUT HOSPITAL ASSOCIATION, Conn. Light & Power Co., Berlin, Conn., Nov. 13.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 5, 6.

INDIANA HOSPITAL ASSOCIATION, Student Union, Univ. of Ind. Medical Center Campus, Indianapolis, Oct. 9, 10.

INSTITUTE FOR HOSPITAL ACCOUNTANTS, Ritz-Carlton Hotel, Atlantic City, N.J., Oct. 21, 22.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 14, 15.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 6-8.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 9-11.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 17, 18.

NEW ENGLAND HOSPITAL ASSEMBLY, Instructional Conferences, Hotel Statler, Boston, Oct. 17, 18.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 28-30.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Nov. 4, 5.

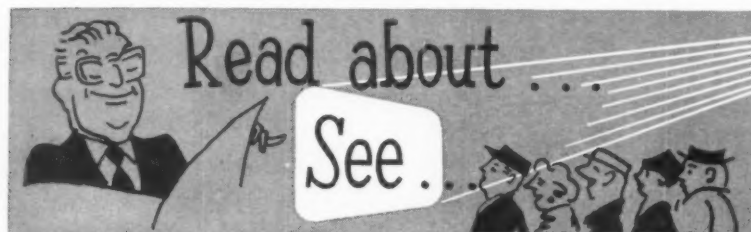
SOUTH DAKOTA HOSPITAL ASSOCIATION, fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15, 16.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 18.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

WORKSHOP ON ASEPTIC TECHNIC, University of Minnesota Center for Continuation Study, Minneapolis, Sept. 16-26.

WORKSHOP ON HOSPITAL CREDIT AND COLLECTIONS, Graduate School of Public Health, University of Pittsburgh, Sept. 13.



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1958

ALABAMA HOSPITAL ASSOCIATION, Hotel Stafford, Tuscaloosa, Jan. 23, 24.

AMERICAN COLLEGE OF SURGEONS, Joint Nurses-Surgeons Meeting, Commodore Hotel, New York, March 3-6.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 21-24.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24, 25.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

GEORGIA HOSPITAL ASSOCIATION, Reiston Hotel, Columbus, Feb. 20-21.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., March 24-26.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fountainbleau, Miami Beach, Fla., May 14-16.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 6-8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-30.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium and Leamington Hotel, Minneapolis, May 14-16.

In figuring your Painting Costs

Here's a Sound Equation

$$\frac{\text{PAINT} + \text{LABOR}}{\text{AREA}} \div \text{YEARS OF SERVICE} = \text{TRUE PAINT COST}$$



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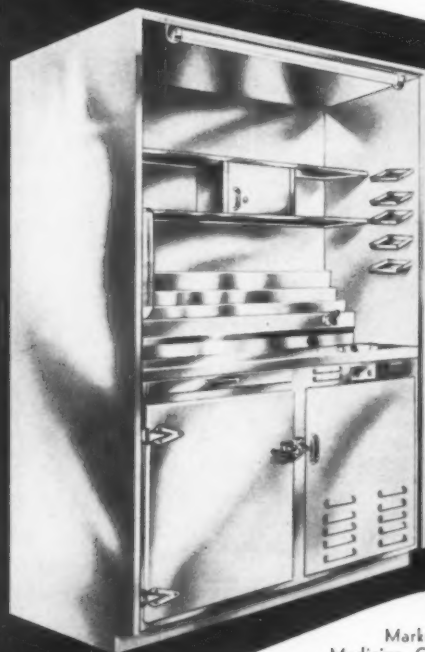
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ABOUT PEOPLE

(Continued From Page 94)

James M. Taylor has been named administrator of General Rose Memorial Hospital, Denver. Mr. Taylor was administrator of Bataan Memorial Hospital, Albuquerque, N.M., during the last year. Before going to New Mexico, he was assistant administrator of General Rose Memorial for five years.

Ernest Williams, administrator of Cullman Hospital, Cullman, Ala., has been named assistant administrator of Carraway-Methodist Hospital, Birmingham, Ala. He was administrator of Beard Memorial Hospital, Troy, Ala., and assistant administrator of Westlake Hospital, Melrose Park, Ill., before assuming the Cullman post two years ago. Mr. Williams is secretary-treasurer of the Alabama Hospital Association and a member of the American Hospital Association. He is a graduate of the hospital administration program of Northwestern University.

Dr. Stanley B. Lindley, director of professional services at the Veterans Administration hospital, Knoxville, Iowa, has been appointed manager of the V.A. hospital at St. Cloud, Minn. The St. Cloud post has been vacant since the death of Dr. Claud Lewis in June.

William A. Lohrey has been named administrator of the Osteopathic Hospital, clinical unit of Kansas City College of Osteopathy and Surgery, Kansas City, Mo. He formerly was business manager of the hospital.

Glenn J. Porterfield has been appointed administrator of Bay Osteopathic Hospital, Bay City, Mich.

Donald E. Hansen has been named acting administrator of Bismarck Hospital, Bismarck, N.D., succeeding Robert F. Bilstein, who resigned. Mr. Hansen, a graduate of Northwestern University's hospital administration course, recently completed a year's residency at the Bismarck hospital.

Robert H. Boone, administrator of Conecuh County Hospital, Evergreen, Ala., has been named administrator of D. W. McMillan Memorial Hospital, Brewton, Ala. He will succeed Chloe C. O'Pry, who has resigned.

Henry D. Hamilton has been appointed assistant director of Muhlenberg Hospital, Plainfield, N.J., succeeding William B. Calvin, whose appointment



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ment, 4%, ear solution, 4%, and nasal solu-
tion, 4%

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125

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as assistant director of Mountainside Hospital, Montclair, N.J., was announced in the June issue of *The Modern Hospital*. Mr. Hamilton formerly was business manager of Delaware Hospital, Wilmington, Del. He is a graduate of the University of Saskatchewan and received his master's degree in hospital administration from Columbia University.

David A. Miller has been appointed administrative assistant for inpatient services at City Hospital, Cleveland. Mr. Miller was administrative resident at the hospital prior to his appointment. He is a graduate of the University of Chicago's hospital administration course.

Dr. Richard B. Bean, area director of professional services in the Veterans Administration area medical office at Boston will become manager of the V.A. hospital in Boston, succeeding **Dr. George P. Denny**, who retired.

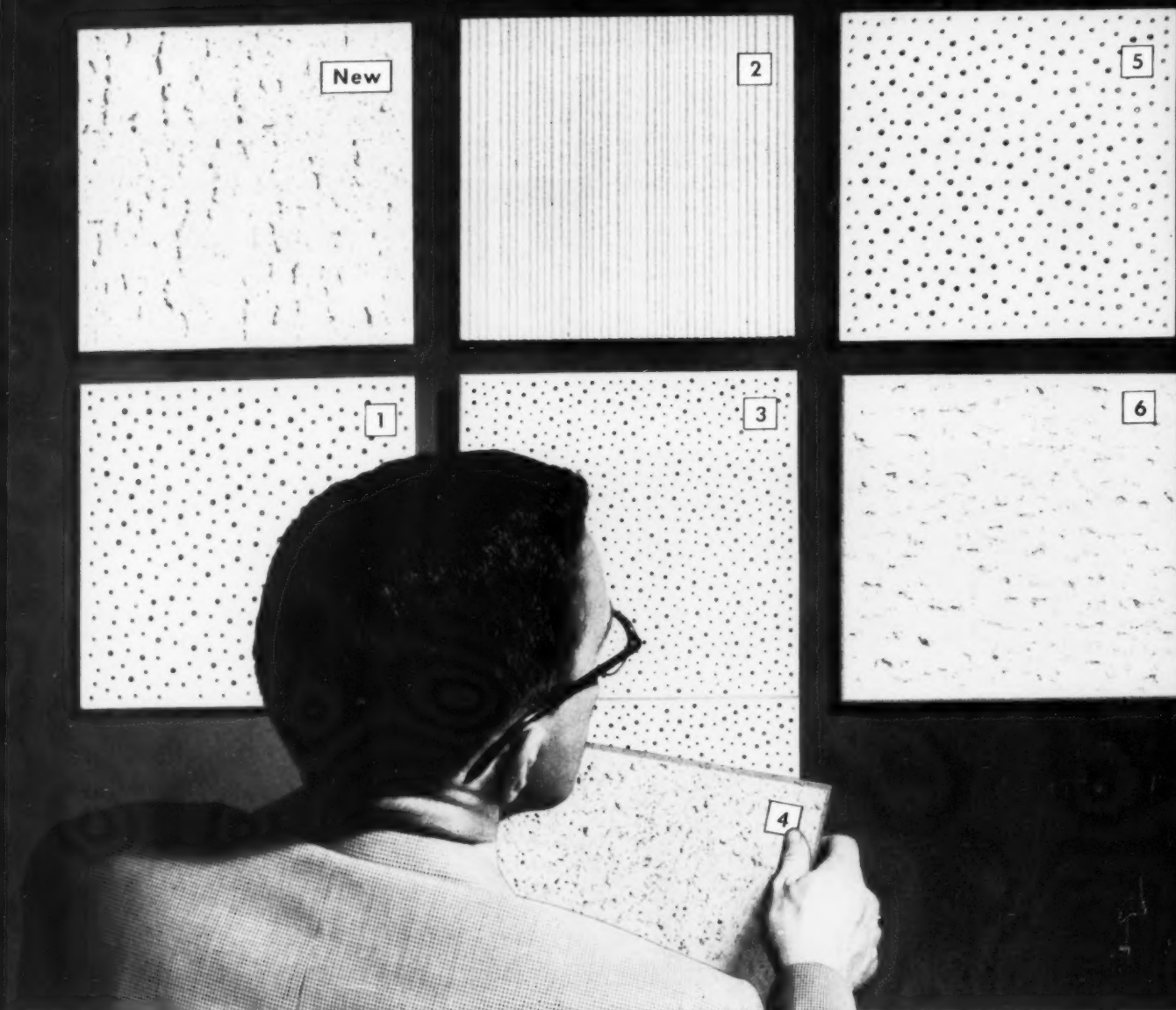
Paul C. Balcom has been named assistant administrator of Franklin Square Hospital, Baltimore. Mr. Balcom is a graduate of the hospital administration program of the University of Minnesota and served his residency at Johns Hopkins Hospital, Baltimore.

Dr. Thomas J. Ready, director of professional services at the Veterans Administration hospital, Providence, R.I., has been transferred as manager of the V.A. hospital at Washington, D.C. He fills the vacancy created by the retirement of **Dr. Edwin J. Rose**. The Veterans Administration also announced that **Dr. Kenneth W. Brown**, director of professional services at the V.A. hospital in Omaha, Neb., has been appointed to the combined position of manager and director of professional services at the V.A. hospital in Clarksburg, W.Va., succeeding **Dr. Louis M. Hohman**, who has retired.

Luke Dufresne has been appointed administrator of Everglades Hospital, Pahokee, Fla. Mr. Dufresne formerly was business manager of Southeast Florida Tuberculosis Hospital, Lantana, Fla. He retired from the navy in 1946 with the rank of commander.

Eugene T. Lasater has been appointed administrator of Ocean Beach Hospital, Ilwaco, Wash., succeeding **Phillip R. Roth**. Mr. Roth's resignation to become administrator of Tri-State Memorial Hospital, Clarkston, Wash., was reported in the July issue of *The Modern Hospital*.

Marvin A. Chapman, director of homes in the department of medicine and surgery at the Veterans Adminis-



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ways. These extra features can provide a big return on the cost of sound-conditioning.

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*TRADE-MARK

tration central office in Washington, D.C., has been named manager of the V.A. center at Wadsworth, Kan. Mr. Chapman will fill the vacancy created by the retirement of **William N. Gregg**.

William H. Wood Jr. has been appointed associate director of Newport Hospital, Newport, R.I. He formerly was assistant director. At the same time it was announced that **Agnes V. Hudder**, who has been director of nursing, will become assistant director for nursing.

Viola Zakman, R.N., director of nursing service at Staten Island Hos-

pital, Staten Island, N.Y., has been appointed to the newly created position of assistant administrator in charge of nursing services.

Douglas Eitel has been appointed assistant administrator of Variety Children's Hospital, Coral Gables, Fla., following completion of his work in the hospital administration program at Northwestern University. Mr. Eitel



Douglas Eitel

served his residency at North Carolina Baptist Hospitals, Winston-Salem, N.C.

W. Earl Willis has joined the staff of Roanoke Memorial Hospital, Roanoke, Va., as assistant administrator. Mr. Willis attended the course in hospital administration at the Medical College of Virginia and served his residency at Roanoke Memorial Hospital and at Richmond Memorial Hospital, Richmond, Va.

Robert E. Moss, administrator of Dukes-Miami County Memorial Hospital, Peru, Ind., has resigned to become administrator of Doctors Hospital, Cleveland Heights, Ohio. Mr. Moss has been head of the Indiana hospital since November 1955. At the same time it was announced that **Joseph R. McFerron** has been named assistant administrator. A graduate of Columbia University's hospital administration program, Mr. McFerron served his administrative residency at Muhlenberg Hospital, Plainfield, N.J.

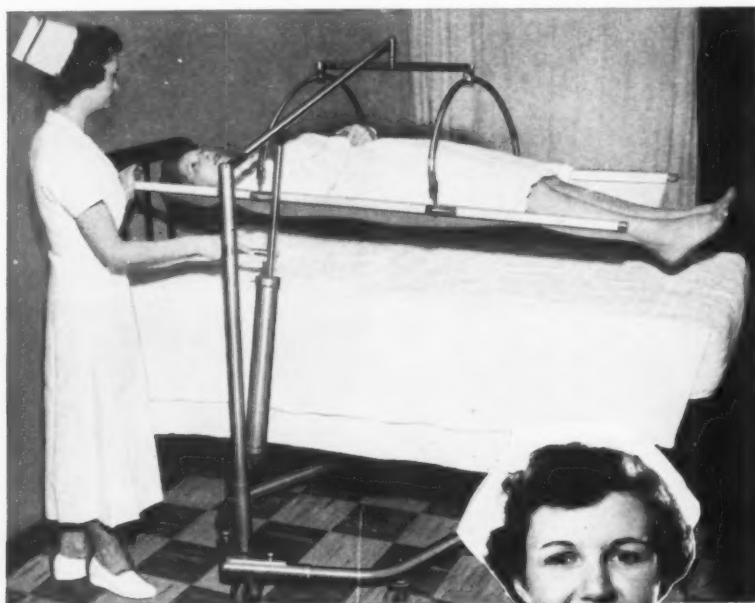
Larry C. Rigsby has been named administrator of Huntsville Hospital, Huntsville, Ala., succeeding **Ned W. Wickham**, who has resigned. Mr. Rigsby had been administrator of Hazard Memorial Hospital, a United Mine Workers' hospital in Hazard, Ky.

William E. Worcester Jr. has been appointed administrator of Valley Hospital, Ridgewood, N.J. A graduate of the University of Vermont, he received his degree in hospital administration from Columbia University. From 1952 to 1954 he was assistant director of Memorial Hospital, Worcester, Mass., and since 1954 he has been assistant director of New England Deaconess Hospital, Boston. **Clarice H. McGarry**, who has been the administrator of Valley Hospital, will serve as consultant to the board of trustees.

Irving B. Harris has been named to the newly created post of executive vice president of Michael Reese Hospital Medical Center, Chicago. A Chicago businessman, Mr. Harris has been a trustee of the hospital since 1952 and chairman of the board of the center's Psychosomatic and Psychiatric Institute since 1954. He is a member of the University of Chicago's council on biological and medical research, founder and president of the American Fund for Psychiatry, and a trustee of other associations. (Continued on Page 174)



Irving B. Harris



in use with therapy tank

interchangeable Head Rest accessory



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2 CAMERAS—choice of vidicon, image orthicon or color cameras

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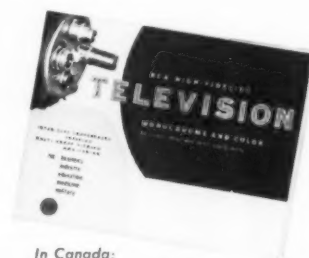
For instruction in medicine and surgery, where live demonstrations via color television offer opportunity for highest realism, system-integrated color cameras will be preferred. A special overhead color camera has been developed to provide a "surgeon's eye view" of operations to any number of students.

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saves 33 $\frac{1}{3}$ % preparation time¹

no more awkward tubes or reels...simple technic frees nurses for other duties.

saves broken glass risks

no nicked sutures...no glass slivers...no punctured gloves...nonirritating jar solution—all important contributions to better patient care.

saves suture strength...flexibility¹

no kinks or weak spots from tight reel winding...eliminates excessive handling...nurse opens sterile sutures as needed to prevent drying out...needle points and cutting edges are better protected.

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far fewer sutures damaged or opened unnecessarily...30% less glove damage...takes half the storage space...initial cost, no more than tubes!

1. Alexander, Edythe L.: Mod. Hosp., May, 1957

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Dr. Sarah Hardwicke has resigned as secretary of the American Hospital Association's Council on Professional Practice to become associate clinical director of the U.M.W. Miners' Memorial Hospitals. Dr. Hardwicke, who was married on August 17 to Dr. Ralph E. Knutti of the National Institutes of Health, Bethesda, Md., will continue to serve the A.H.A. as associate secretary of the council until October 15. She will be succeeded as secretary by Dr. LeRoy E. Bates, who has served as associate secretary of the council since 1956.

William B. Robinson has resigned as administrator of Burnham City Hospital, Champaign, Ill., to become administrator of Ryburn Memorial Hospital, Ottawa, Ill. He succeeds Dwayne Hall.

William Wrigley has been appointed administrative assistant at J. C. Lincoln Hospital, Phoenix, Ariz. Previously, Mr. Wrigley was regional administrator of seven Lutheran hospitals in Montana, North Dakota and South Dakota.

Dr. Paul Benton, administrator of Children's Medical Center, Tulsa, Okla., has resigned to devote full time to the

Tulsa Child Guidance Clinic. His successor has not been named.

James N. Sudduth, a recent hospital administration graduate of Northwestern University, has been named administrator of Chilton County Hospital, Clanton, Ala. He succeeds Carden M. Astin.

Major Margaret Norris of the Salvation Army has been named superintendent of Booth Memorial Hospital, Wichita, Kan., replacing Major Blanch Moberry, who has been assigned to a post in Grand Rapids, Mich.

Hal V. King has been named assistant administrator of Salem Memorial Hospital, Salem, Ore., following completion of his administrative residency at Swedish Hospital, Seattle. He is a graduate of Northwestern University's course in hospital administration.

Leslie D. Feedback has been appointed assistant administrator of Alton Memorial Hospital, Alton, Ill. Mr. Feedback is a graduate of Washington University's course in hospital administration and served his administrative residency at Wesley Hospital, Oklahoma City, Okla.

James P. Wilkins has been named administrative assistant of Burge Hospital, Springfield, Mo. Mr. Wilkins, who has been serving as personnel officer of William Beaumont Army Hospital, Fort Bliss, Tex., will be responsible for patient care, professional services, and personnel at Burge.

Margaret Lamb, former administrator of Norman Municipal Hospital, Norman, Okla., and a past president of the Oklahoma Hospital Association, has come out of retirement to accept a position as assistant superintendent of Children's Convalescent Hospital, Bethany, Okla.

Department Heads

Robert S. Salisbury and Lewis W. Sykes have been appointed assistant directors of the outpatient department at Duke Hospital, Durham, N.C. Both



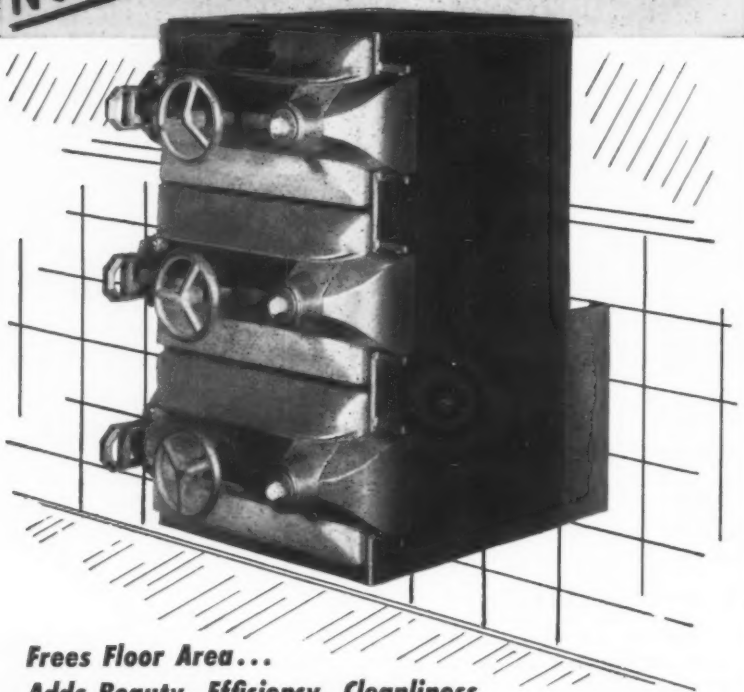
Robert S. Salisbury



Lewis W. Sykes

positions have been created as part of the current expansion of the department. Mr. Salisbury's work will in-

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clude business management of the medical divisions, while Mr. Sykes will have comparable duties in the surgical divisions. Mr. Salisbury previously was associated with the U.S. Public Health Service as an epidemiological investigator; he received his master's degree from Columbia University. Mr. Sykes received his bachelor's degree in industrial management from Georgia Institute of Technology and has completed a year of graduate study in business administration at the University of North Carolina.

Franklin E. Denning, office man-

ager of Newport Hospital, Newport, R.I., has been appointed controller.

Elinor Fay has been named director of volunteers and auxiliary coordinator of Western Pennsylvania Hospital, Pittsburgh. She formerly was director of volunteers and executive secretary of the auxiliary at Massachusetts Memorial Hospitals, Boston.

Rita C. Coll has been appointed edu-



Elinor Fay

cational director of Temple University Hospital School of Nursing, Philadelphia, succeeding Rena L. White, who retired in July after 17 years of service. Miss Coll previously was an instructor in the two-year and four-year educational programs at the University of Pennsylvania School of Nursing. She has been nursing arts instructor at Grandview Hospital, Sellersville, Pa., and medical clinical instructor at Bryn Mawr Hospital, Bryn Mawr, Pa.

Virginia Rine, formerly associated with the Veterans Administration hospital in Oakland, Calif., has been named head dietitian at Yakima Valley Memorial Hospital, Yakima, Wash. She is a graduate of the University of Montana and took her internship at King County Hospital, Seattle.

Ernest C. Nott Jr., formerly administrative resident at Baptist Memorial Hospital, Jacksonville, Fla., has been named director of personnel and public relations. Mr. Nott received his master's degree in hospital administration from the Medical College of Virginia. It was also announced that Joseph I. Hutchinson, administrative resident, has been appointed staff assistant executive housekeeper for Baptist Memorial Hospital.

Janet Morgan has been appointed librarian of the Pottsville Hospital School of Nursing, Pottsville, Pa. Miss Morgan has been associated with the Army Medical Library in Washington, D.C., and the air force special services department.

Deaths

Guy J. Clark, an honorary fellow of the American College of Hospital Administrators, died of a heart ailment July 2 in Cleveland.



Guy J. Clark

Nationally known in the field of hospital administration, Mr. Clark was executive secretary of the Cleveland Hospital Council from 1926 to 1954. At the time of his death he was executive director of the Hospital Finance Corporation, which was established in 1933 on his recommendation. He was a past president of the Ohio Hospital Association, a former chairman of the council on administrative practice of the American Hospital Association, and served a three-year term as trustee of the A.H.A. He was active in the development of the Cleveland Hospital Service Association.

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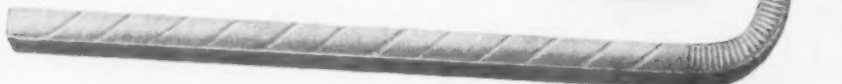
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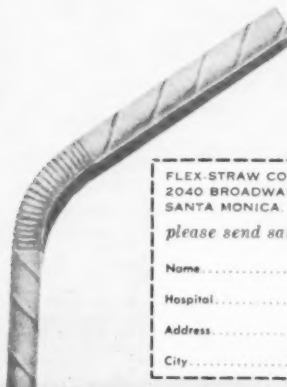


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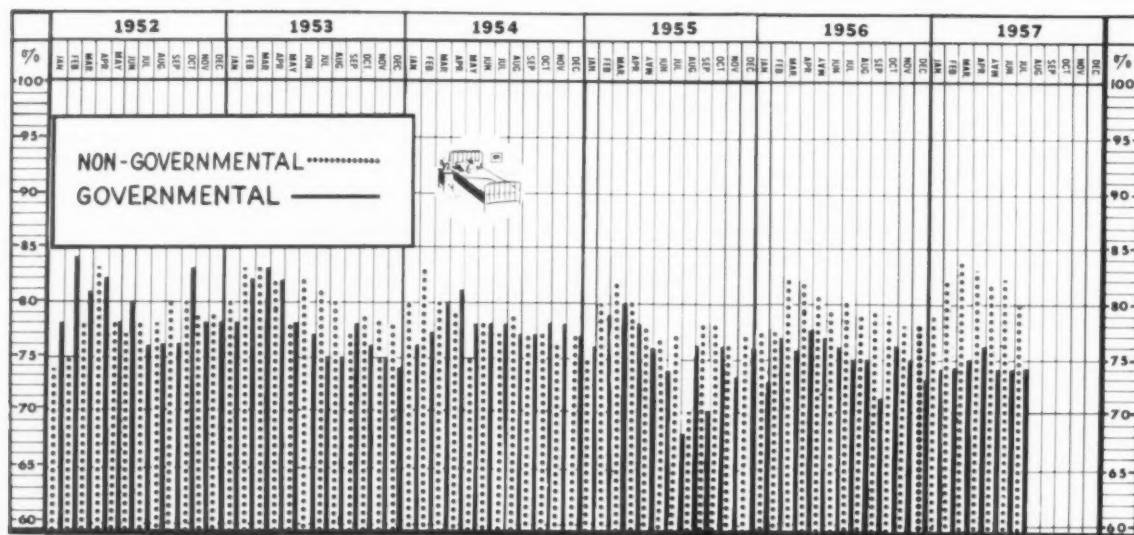
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Voluntary Hospital Occupancy Increases



Government hospitals reporting to the Occupancy Chart for the month of July 1957 show occupancy at 73.9 per cent of capacity. Voluntary hospitals reported occupancy at 79.9 per cent of capacity. Last year, percentages

of 74.8 and 78.8, respectively, were reported.

The current 109 building projects reported for the period July 8 through August 5 totaled \$93,936,330, bringing the year's total thus far to \$588,-

253,812. During the corresponding period last year, construction totaled \$92,144,140 and brought the 1956 aggregate then to \$532,095,351. Eighteen hospitals and 74 additions were reported during the current period.



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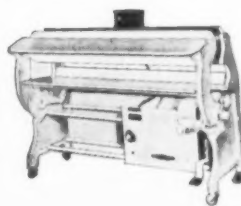
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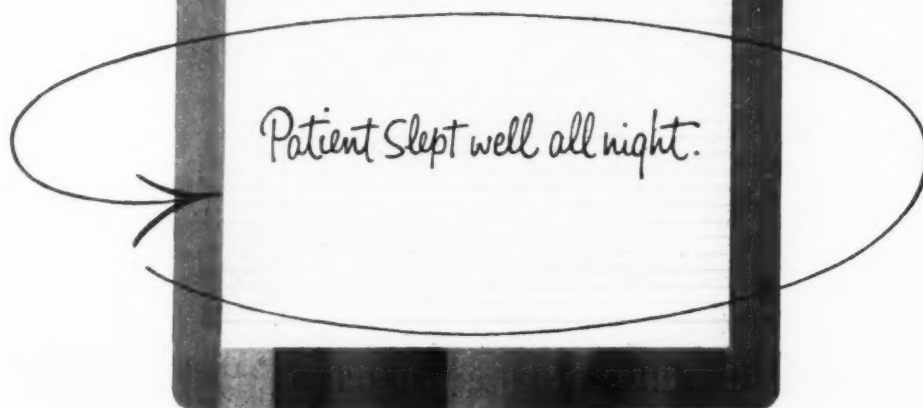
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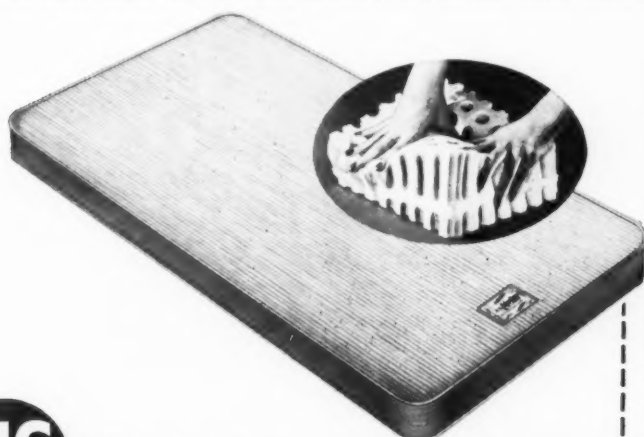
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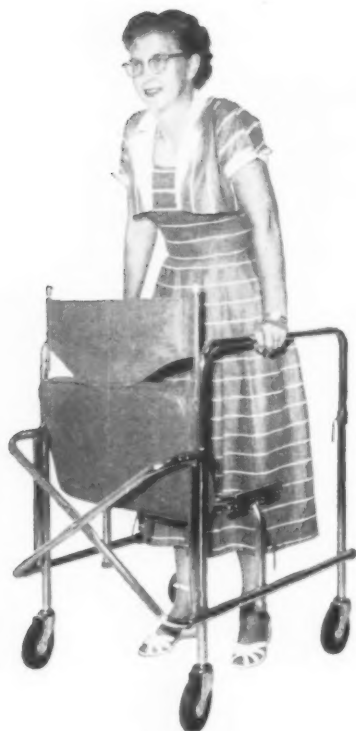
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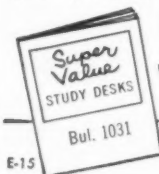
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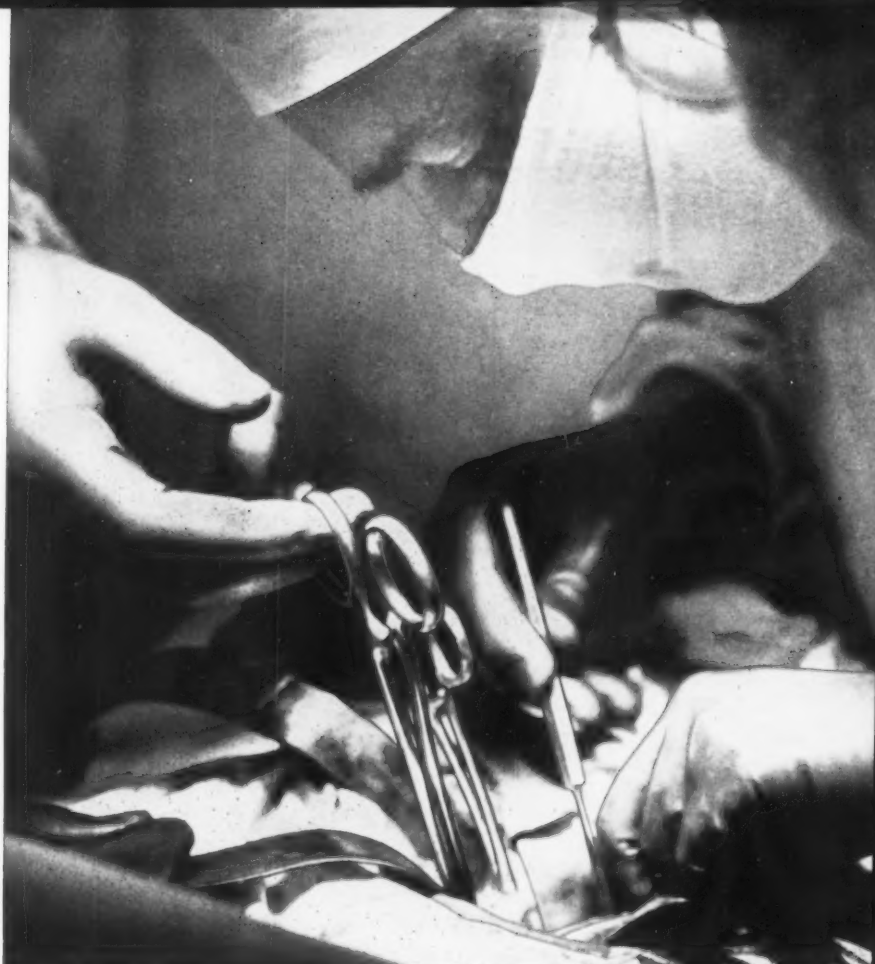
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ADMINISTRATOR or ASSISTANT—Management specialist, age 37, with experience in sales, personnel, office procedures, purchasing, maintenance and repairs, etc. B.A. Degree, Monmouth College; fifteen years experience and interest in health field and administration, fund raising, and community problems; married, two children; finest references and credentials; will relocate anywhere. Reply Mr. Maurice A. Garland, 723 East Euclid Avenue, Monmouth, Illinois. Telephone 887.

ADMINISTRATOR—9 years, 250-bed general hospital; chief accountant; administrative assistant, 4½ years assistant; experience embraces all phases of hospital administration, considerable direct relations with medical staff; planning, equipping, staffing new hospital; Member ACHA-34. Apply MW 202, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

CLINIC MANAGERSHIP—Wanted by former public accountant with hospital and industrial background; presently employed; age 47, married, minimum salary \$8000. Apply MW 203, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

PERSONNEL DIRECTOR or Assistant; East or West coast preferred; good experience. Apply MW 204, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.



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ADMINISTRATOR—Professional nurse; B.S. in Nursing; M.P.H., (Hospital Administration); three years, assistant administrator, 250-bed general hospital.

ASSISTANT ADMINISTRATOR—M.S. (Public Health Administration); M.H.A. (Hospital Administration); administrative internship, three years assistant administrator, 400-bed hospital.

COMPTROLLER—B.S.; accounting manager five years, comptroller two years, 550-bed hospital; two years, director department, 1000-bed hospital.

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(Continued on page 184)

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ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

COMPTROLLER—To supervise and direct entire accounting operation; must have good background in general accounting and cost analysis; a degree in accounting or business administration with a major in accounting or equivalent education and business experience required; interested applicant should write to MO 205, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

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DIETITIAN—Chief of Department; ADA member or equal qualifications; modern 90-bed hospital; J.C.A.H. approved. Apply Superintendent, Grace Hospital, 2307 W. 14th Street, Cleveland, Ohio.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at \$300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Therapeutic; A.D.A. member, to supervise tray service, dietary personnel and counsel patients; no teaching required; hospital recently expanded to 450-beds, located in desirable residential district; approved by Joint Commission; dietary facilities entirely new and air conditioned; dietetic program integrated with approved school of nursing, affiliated with Medical Research Institute; 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIAN—Assistant; 150-bed general hospital; excellent opportunity to gain therapeutic and administrative experience; salary open; liberal personnel policies. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

DIETITIAN—Chief; college degree, A.D.A. member, experience in supervision and marketing; \$400 per month start; liberal personnel policies; good working conditions. Write Personnel Office, The Queen's Hospital, Box 614, Honolulu, Hawaii.

DIRECTOR OF NURSING—Progressive State hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from \$4300 to \$7800 plus self maintenance; liberal sick time, holidays, paid vacation. Write to Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

DIRECTOR OF NURSING SERVICE—Immediate opening; salary \$7000 to \$7500 per year; must be degree graduate with administrative experience; no school of nursing; liberal personnel policies in modern hospital in the Detroit vicinity. Contact Personnel Director, Pontiac General Hospital, Pontiac, Michigan.

DIRECTOR OF NURSING—Bismarck Hospital, Bismarck, North Dakota; 175-beds; must have degree in nursing education and nursing service; salary open; Protestant hospital. Apply to H. J. Bischof, President Board of Trustees, Bismarck Hospital, Bismarck, North Dakota.

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INSTRUCTOR—Obstetric nursing; in a fully accredited school of nursing; 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages; college affiliation; housing available; liberal personnel policies; salary open. Apply MO 180, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTORS—Clinical; for operating room technique and in medical and surgical nursing, day, evening and night shifts; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open, 40 hour work week; 20 working days vacation; sick benefits; position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTORS—Psychiatric clinical nursing; (3) progressive State hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from \$3120-\$4300 plus self maintenance; liberal sick time, holidays, paid vacation. Write to Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Psychiatric nursing; progressive State hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from \$4300 to \$6000 plus self maintenance; liberal sick time, holidays, paid vacation. Write to Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Clinical; medical and surgical nursing, for both formal and clinical teaching; admit one class a year; three year diploma program, university affiliated; salary based on qualifications; excellent personnel policies; no nursing service duties; hospital conveniently located near New York City. Apply Director, School of Nursing, Presbyterian Hospital, Newark, New Jersey.

INSTRUCTOR—Clinical-psychiatric nursing; for our affiliate psychiatric school of nursing; BS degree in Nursing Education, post graduate preparation in psychiatric nursing, ability to supervise and to teach nurses and aides in clinical area; salary open; 40 hour week with excellent benefits. Write to Personnel Supervisor, State Hospital, Jamestown, North Dakota.

LIBRARIAN—Medical records; registered or eligible for registration, to head the department in a 500-bed tuberculosis hospital; liberal holidays, vacations, sick leave benefits and pension plan. Apply Medical Director, P. O. Box 1411, Lantana, Florida.

LIBRARIAN—Medical record; with demonstrated successful experience to serve as chief of department for 400-bed non-profit accredited teaching hospital which includes 115-bed pediatric unit; desire person capable of taking over current department with able assistants and with ability to supervise personnel and organize paper work flow and to adjust departmental work loads. Apply Personnel Director, Iowa Methodist Hospital, Des Moines, Iowa—friendly capital city of Iowa which includes campus of Drake University.

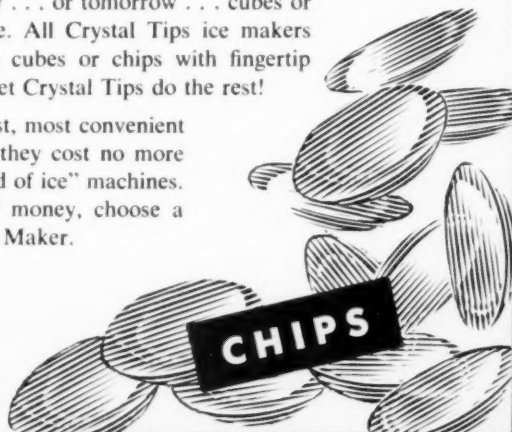
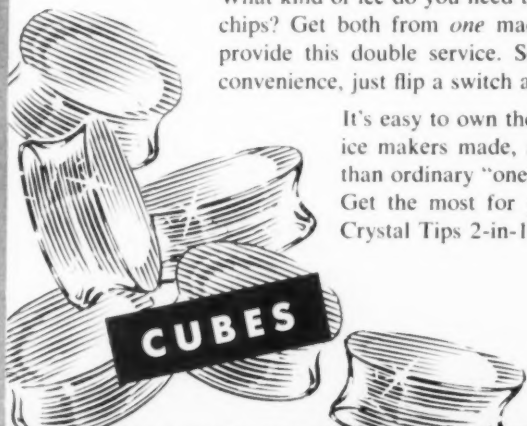
(Continued on page 186)

EVERY *Crystal Tips* ICE MAKER

Supplies 2 Kinds of ICE at no Extra Cost!

What kind of ice do you need today . . . or tomorrow . . . cubes or chips? Get both from *one* machine. All Crystal Tips ice makers provide this double service. Select cubes or chips with fingertip convenience, just flip a switch and let Crystal Tips do the rest!

It's easy to own the best, most convenient ice makers made, and they cost no more than ordinary "one kind of ice" machines. Get the most for your money, choose a Crystal Tips 2-in-1 Ice Maker.

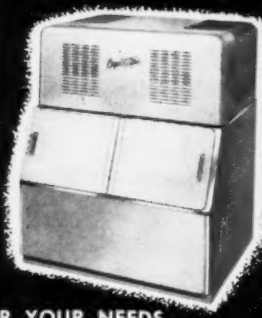


NEW MODEL B-500-B — 2-in-1 ice service and large capacity combined in one space saving model. Produces up to 1/4 ton of cubes or chips per day.

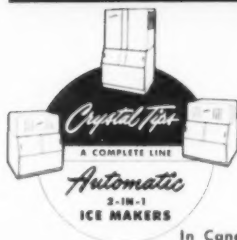
MODEL B-200-B — Convenient under-counter design; 24 hour capacity storage bin. Produces up to 175 lbs. of cubes or chips per day.



MODEL B-300-B — Dependable, trouble-free operation; produces up to 220 lbs. of cubes or chips per day. Full width access doors standard on all models.



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Faribault, Minnesota

☐ Please send complete information about 2-in-1 Crystal Tips Ice Makers.

☐ Model B-500-B ☐ Model B-300-B ☐ Model B-200-B

Name _____

Address _____

City _____ State _____

classified advertising

POSITIONS OPEN

LIBRARIAN—Chief medical records-registered; 200-bed pediatric teaching hospital. Apply Administrator, St. Louis Children's Hospital, 500 S. Kingshighway, St. Louis, Missouri.

LIBRARIAN—Medical records; registered or eligible for registration to head department at 250-bed fully accredited teaching hospital; salary open, excellent holiday, vacation, sick leave benefits. Contact James B. Moore, Assistant Administrator, Passaic General Hospital, Passaic, New Jersey.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

MISCELLANEOUS—City of Flint; excellent opportunities in progressive city of 200,000; General Duty Nurse in 629-bed hospital; salary \$3952-\$4732; Occupational Therapist to help organize and direct new OT department; salary \$4664-\$5577; Junior Public Health Nurse, \$3952-\$4732; Senior Public Health Nurse \$4329-\$5161; sick, annual and longevity benefits excellent. Write Civil Service Commission, City Hall, Flint 2, Michigan.

MISCELLANEOUS—Supervisor and Head Nurse; Evening duty; 211-bed modern children's hospital offering 13 weeks program for

basic nursing students from diploma schools; at least 5 years experience required for supervisor; at least 3 years experience required for head nurse; starting salary dependent upon qualifications; liberal vacation and sick leave policy; 40 hour week. Write Director of Nursing, The Children's Hospital, Cincinnati 29, Ohio.

NURSE—Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary \$300 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Di-

rectress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut, Tel. Westport—Capital 7-5105.

NURSING—Staff; annually \$3000 to \$3360 plus two meals daily and uniform laundry, six paid holidays, liberal sick leave and vacation. Apply Director of Nursing, Episcopal Eye, Ear and Throat Hospital, 1147 15th St., N.W., Washington 5, D.C.

NURSES—Registered; immediate openings; starting salary \$240 month with opportunity for advancement; room, board and laundry annual vacation, liberal sick leave, 40 hour, 5 day week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

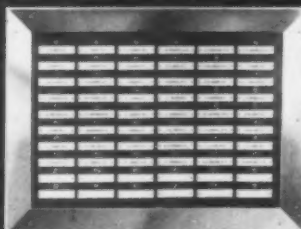
NURSE—Registered; for thirty-eight bed general hospital; salary \$270.00 per month with periodic increases; excellent personnel policies. For further information apply Superintendent of Nurses, Red Wing City Hospital, Red Wing, Minnesota.

NURSES—Registered; psychiatric hospital; liberal personnel policies; 40-hour week, attractive residence; positions available on all shifts; differential salary for evening and night service. Inquire Director of Nurses, Essex County Overbrook Hospital, Cedar Grove, New Jersey.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

(Continued on page 188)

**ONLY
\$595**
Complete



DOCTORS' REGISTRY

Complete Unit—Ready For Installation

60 unit board (illustrated) only \$595.00
96 unit board only 695.00

- Toole Registries are sold direct... no middlemen to slow up delivery or disclaim responsibility.
- 2 or more boards may be hooked up for remote operation.
- Accepted, approved and specified by leading Western hospital architects.
- Toole Registry Boards are unique for ease of maintenance, bulb and name plate replacement.
- Only 5 day delivery on name replacements. You deal directly with engraver.
- Multiple or special type boards available.
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- For New Construction: Flush mount in wall. 3" wide architectural aluminum molding.
- For Existing Hospitals: Surface mount; bevelled-to-wall stainless steel frame.
- 30 day delivery.
- Write for information.

Electronics Division **TOOLE ENGRAVING CO.**
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to perfect these fine needles**

BERBECKER Surgeons' Needles are imported from an English town composed almost entirely of needle makers. Here high inherited skill, enhanced from generation to generation, produces surgeons' needles which we believe are unexcelled anywhere in the world. Your dealer can always supply BERBECKER.

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Made in England for the Surgeons and Hospitals of America

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Ten years ago Hartford Hospital pioneered in the use of piped medical gases for anaesthesiology. Schrader cooperated with the hospital in de-

sign and production of safety-keyed outlets. Today, this system is still operating efficiently.

Schrader medical gas outlets have served ten years...dependably, safely, conveniently

Medical gas plug-in systems were pioneered by Schrader in cooperation with the Hartford Hospital a decade ago... these fittings are still in use today.

In the years since the original Hartford installation, Schrader has continued to design new and improved equipment for piping medical gases. Today, hospitals can have either Schrader safety-keyed flush-mounted or exposed outlets for oxygen, nitrous oxide, vacuum and air. You can't

plug the adapter into the wrong unit. For added safety, each outlet is color keyed for the gas handled.

The new Schrader outlets can be coupled or uncoupled by a single-handed operation. Just plug in lines, or disconnect, with one motion. They're as easy to install as electric outlets. Either type will be shipped complete and ready for installation after complete inspection test. Write for further details.

LATEST SCHRADER SAFETY-KEYED OUTLETS FOR MEDICAL GAS PIPING NOW AVAILABLE



A. SCHRADER'S SON
Division of
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Schrader®
a division of **SCOVILL**

FIRST NAME IN SAFEST
MEDICAL GAS CONTROL OUTLETS

classified advertising

POSITIONS OPEN

NURSES—Staff: Portland, Oregon is a fine place to live; we think the University of Oregon Medical School Hospital is a fine place to work; openings for staff nurses in pediatric, medical surgical, operating room and psychiatric units; starting salary for those with six months' or more experience—\$310.00 per month; liberal personnel policies; opportunities to take classes in graduate nurse programs on campus at reduced tuition rates. Write for further information to Director of Nursing Service, University of Oregon Medical School Hospital, Portland 1, Oregon.

NURSE—Operating room; experienced; 200-bed tuberculosis hospital; maintenance provided. Send complete resume to Mrs. Huegel, Eagleville Sanatorium, Box 45, Eagleville, Pennsylvania.

NURSES—Registered; beginning salaries for rotating staff nurses \$290 per month; permanent evenings or nights, and OR nurses, \$304 per month; air conditioned teaching hospital in resort town; swimming, boating, fishing; 1 hour from large city; opportunity for advanced study leading to B.S. and M.S. Degrees. Write Director, Nursing Service, University of Texas Medical Branch, Galveston, Texas.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; \$3,000 per year, board, room and laundry available at \$480 per year; social se-

curity and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; for general duty for 150-bed tuberculosis sanatorium in Bartlett, Alaska; starting salary \$353 per month with a \$10 raise each six months to a maximum base pay of \$383; \$10 extra for evening and night shift; 8 hour day, 40 hour week, 8 to 4, 4 to 12, 12 to 8 shifts; complete maintenance available for nominal sum; new modern nurses residence; also opening for night supervisor. Write to Director of Nurses, Seward Sanatorium, Bartlett, Alaska.

PATHOLOGIST—Certification required; salary \$1066. Write immediately to Personnel Director, Department of Civil Service, County of Hawaii, Hilo, Hawaii.

RADIOLOGIST—Certification required; salary \$1066. Write immediately to Personnel Director, Department of Civil Service, County of Hawaii, Hilo, Hawaii.

SUPERVISOR—Housekeeping; salary \$5237 to \$5957 per year; this is a new executive housekeeping position in a 450-bed general hospital located 17 miles from downtown Detroit; duties will include internal administration of the housekeeping department and supervision of cleaning and decorating in the hospital; experience on a responsible supervisory level in the housekeeping department of a large hospital or hotel is required. For further information write to Dr. Douglas McDowell, Wayne County General Hospital and Infirmary, Eloise, Mich.

SUPERVISOR—Assistant; in operating rooms; 300-bed hospital; adequate, modern equipment; 40 hour week; 20 paid days vacation, cash salary; liberal personnel policies; preparation and experience desired; salary open. Apply, Director of Nursing, Mercer Hospital, Trenton, New Jersey.

TECHNOLOGIST—Laboratory; 250-bed hospital; salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; A.S.C.P.; 40-bed general hospital in excellent hunting and fishing area; \$375.00 to \$400.00 per month. Apply Miss Martha Hanson, Administrator, Baraga County Memorial Hospital, L'Anse, Michigan.

TECHNOLOGISTS—Medical; (2); modern expanding Cumberland Valley Hospital; fully approved; college town; 40 hour week, 10 days sick leave, social security, 2 weeks vacation, congenial relationships; maintenance if desired; automatic annual increments; start \$3720 per year. Apply F. J. O'Brien, Administrator, Chambersburg Hospital, Chambersburg, Pennsylvania.

TECHNOLOGIST—Clinical laboratory; registered or qualified for 600-bed tuberculosis hospital; 40 hour week plus calls; paid vacation and sick leave; salary \$397 to \$338 according to experience. Apply Firland Sanatorium Laboratory, 1704 E. 150th St., Seattle 55, Washington.

(Continued on page 190)

Quiet, Dependable KILIAN BALL-BEARING CASTERS

GUARANTEED IN HOSPITAL SERVICE Five Years Without a Failure



Quality built to insure positive swiveling, based on patented bearing structure.

All metal parts are machined from bar stock fully heat treated for years of continuous use. Forks and brakes are made of malleable iron to withstand excess abuse.

All exposed parts are cadmium plated for better appearance and to counter corrosion.

At the Hospital for Sick Children in Toronto, for example, every bed, cot, and mobile equipment were fitted with Kilian casters. **NOT ONE CASTER FAILURE WAS REPORTED IN FIVE YEARS OF CONSTANT USE.**

You can profit from the experiences of institutions like the Hospital for Sick Children by insisting on Kilian Casters.

Write today to find out
how you can get Kilian
casters on your equipment.

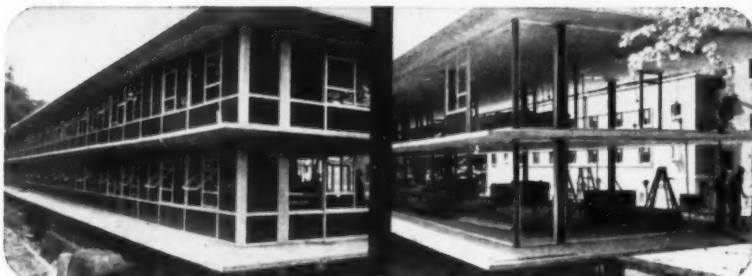
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MANUFACTURING CORP.
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MANUFACTURING CORP.,
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Toronto, Ontario, Canada

How to simplify and cut costs of
Your wall construction with

BAYLEY CURTAIN WALL SYSTEMS



After Curtain-Wall is installed.

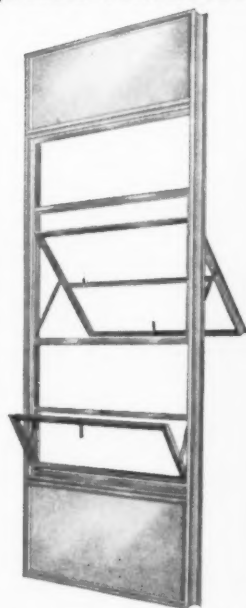
Before Curtain-Wall is installed.

—incorporating BAYLEY Projected Windows and Decorative Panels

Bayley Curtain Wall Systems—in either aluminum or steel—offer you the maximum economies to be realized from modern curtain-wall construction. Incorporating standard time-proved Bayley Projected Window Units, and a Bayley system of sub-frame assembly, a designer's preference can be met without the costliness of special window designing. Also, as illustrated, installation is reduced to the simplest procedure. Other advantages accruing are:

- ✓ Permits a choice of decorative panels and individualized arrangements
- ✓ Provides an insulated wall treatment to suit the building's appropriation
- ✓ Designed to accommodate a building's movement — expansion and contraction
- ✓ Provision against condensation annoyance or damage
- ✓ A wall with any desired degree of air, light or vision
- ✓ Centralized responsibility for the complete wall system — including sub-frames, windows and panels

For further information write; or call your local Bayley Representative; or see Sweets.



The Bayley Series A-450
Aluminum Curtain-Wall Unit.



Write To-
day for this
Curtain-
Wall Idea
File.

THE WILLIAM BAYLEY COMPANY

Springfield, Ohio

District Sales Offices: Springfield Chicago 2 New York 17 Washington 16



1. Bolting sill and header plate into position.

2. Bolting jamb plate to load-bearing column.



3. Interlocking window-panel into position.



4. Caulking interlock grooves before positioning mullion.

5. Positioning Bayley adjustable-width mullion.



6. Positioning window-panel — using interlock groove as slide.



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POSITIONS OPEN

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

TECHNICIAN—Laboratory and X-ray; male or female; ASCP registration preferred; experience as X-ray technician also required; salary \$315 to \$377. Write Personnel Director, Department of Civil Service, County of Hawaii, Hilo, Hawaii.



The Medical Bureau

M. BURNICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE CHICAGO

ADMINISTRATORS — (a) Medical director; new 85-bed hospital; active outpatient clinic, 500 patients monthly; California; \$15,000. (b) Medical director; new 200-bed hospital special-

MEDICAL BUREAU—Continued

izing geriatrics; preferably general practitioner or internist; opportunity teaching medical school 20 miles away; midwest. (c) Assistant medical director; duties include directing resident program; 450-bed hospital; interesting city outside continental U.S.; delightfully equable climate. (d) Administrator; relatively new general hospital; college town, midwest. (e) Experienced administrator; new general hospital, 60 beds; small town near medical school city, east. (f) Administrator; general 250-bed hospital; \$10,000, maintenance; New England. (g) Assistant administrator; 300-bed general hospital; preferably one with full potential for top position; California. (h) Assistant; preferably young administrator experienced in public health work; outside U.S. (i) Woman administrator; RN or graduate of course in Hospital Administration; California.

ANESTHETISTS—(a) Sole responsibility 70-bed hospital, new surgery; \$600, complete maintenance; near Omaha. (b) Replace M.D., 56-bed hospital, Illinois-Indiana border; \$7200. (c) Chief, staff includes four R.N.'s four M.D.'s, 400-bed hospital; \$6000; ideal Florida coast area. (d) Two; large general hospital; college town Rocky Mountains, excellent recreation; best salary offer.

DIRECTOR OF NURSING — (a) Director nursing service, 400-bed general hospital, all graduate staff; Greater Manhattan; \$9000. (b) Director school and service; 350-beds; 237 students; collegiate program; university city; mid-

MEDICAL BUREAU—Continued

west; attractive contract. (c) Associate director nursing; 450 bed hospital; 150 students, diploma program; excellent southwest resort area; salary commensurate ability. (d) Assistant director education; complete responsibility school of 200; renowned hospital; outside U.S.; \$6000 up; ideal climate. (e) Director school, service; 450-bed hospital; southern resort city; best financial arrangement.

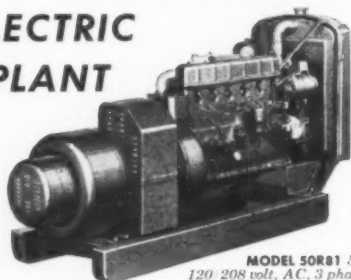
DIETITIANS—(a) Chief, 350-bed hospital on Atlantic seaboard; excellent opportunity person with initiative; attractive contract. (b) Chief; 500-bed hospital; leading midwest city; reorganization ability desirable; \$7200.

EXECUTIVE HOUSEKEEPER—(a) 700-bed hospital; leading industrial city; top administrative ability; better than average salary.

EXECUTIVE PERSONNEL—(a) Comptroller; 200-bed general hospital; expansion program; college town, midwest. (b) Business manager; 400-bed general hospital; graduate of course in administration with experience in accounting required; \$600-\$700; east. (c) Personnel director; 600-bed hospital affiliated research institution; 1200 employees; east. (d) Purchasing agent; 400-bed hospital; Wisconsin. (e) Engineer, civil or mechanical, preferably experienced Hill-Burton hospitals; \$10,000. (f) Food supervisor; outstanding opportunity, 500-bed hospital; organizational ability desirable; attractive contract; large Eastern city.

(Continued on page 192)

KOHLER offers a NEW 50 KW STAND-BY ELECTRIC PLANT



MODEL 50RB1 50 KW,
120/208 volt, AC, 3 phase, 4 wire.
Remote starting. Other sizes
1000 watts to 50 KW.

Maximum protection when power fails

This new Kohler 50 KW gasoline operated generator set, powered by a heavy duty, 6 cylinder engine, insures smooth, quiet operation for hospital stand-by needs. High capacity with ample overload assures adequate power for operating room, nurses' call bell system, emergency lighting, X-ray, heating system, isolation ward, O.B.S.

and patient elevators. Write for folder 3-C.

Visit the Kohler exhibit at the
**AMERICAN HOSPITAL
ASSOCIATION CONVENTION**
Atlantic City, Sept. 30 to Oct. 3

Kohler Co., Kohler, Wisconsin. Established 1873

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PLUMBING FIXTURES • HEATING EQUIPMENT
ELECTRIC PLANTS • AIR-COOLED ENGINES • PRECISION CONTROLS

HOW MUCH DO YOU KNOW ABOUT PUBLIC SEATING?

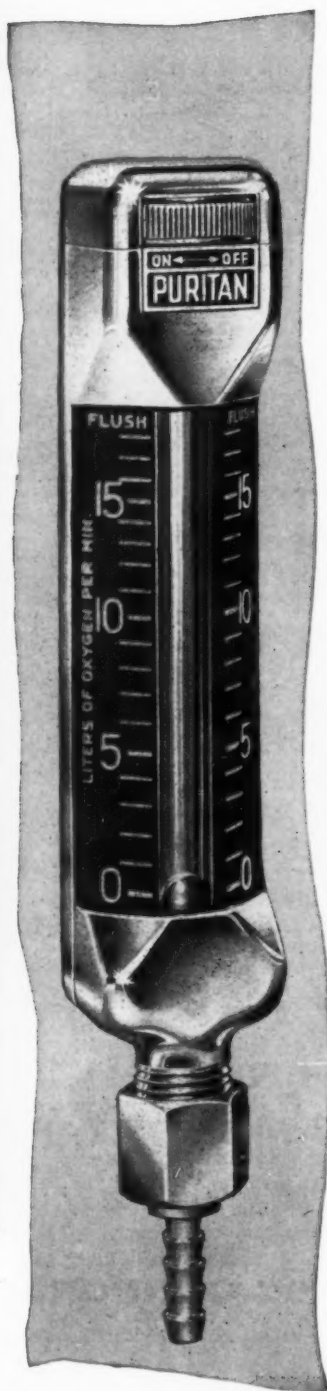


CHECK LIST	
<input checked="" type="checkbox"/>	Strength
<input checked="" type="checkbox"/>	Color
<input checked="" type="checkbox"/>	Safety
<input checked="" type="checkbox"/>	Durability
<input checked="" type="checkbox"/>	Style
<input checked="" type="checkbox"/>	Comfort
<input checked="" type="checkbox"/>	Versatility
<input checked="" type="checkbox"/>	Size
<input checked="" type="checkbox"/>	Maintenance
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Every one of these desirable qualities is built right into Hampden all-steel folding furniture. All of these features are important to you. Whatever your specific needs, a modern Hampden public seating chair has been designed to do the job best — at lowest cost. For detailed information on the most complete line of adult and juvenile public seating, write today direct.

Easthampton, Massachusetts
Department HS-5

*The
Strength
of Metal
Where You
Need It!*



From your oxygen flowmeters, you have the right to expect years of rugged service—without maintenance or delicate handling.

Puritan's handsome, chrome plated metal body shields the plastic calibrated flow tube from damage and assures the necessary strength required by daily use.

In Puritan Flowmeters, this time-tested design principle is combined with such unexcelled performance characteristics as:

- ... flow accuracy unaffected by back pressure.
- ... usable with every type of administering equipment.
- ... dependable readings under all conditions.
- ... easy to read and adjust.
- ... usable with Regulators or Piping Systems.

*You Pay
No More for the
Very Best When You
Insist on the*
**PURITAN
PRESSURE COMPENSATED
FLOWMETER**

Puritan 
COMPRESSED GAS CORPORATION
SINCE 1913
KANSAS CITY 8, MO.
PRODUCERS OF MEDICAL GASES
AND GAS THERAPY EQUIPMENT

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—Continued

FACULTY POSTS—(a) Dean, state college nursing program, \$8000 up. (b) Assistant dean; well established collegiate school nursing; predominantly administrative duties; near Texas border; excellent salary potential. (c) Chairman, department, medical-surgical nursing; renowned university; near New York City; \$450 month academic year. (d) Instructor, science; teach anatomy, physiology, pharmacology; \$5000; hospital Chicago area.

MEDICAL RECORD LIBRARIANS—Director-instructor; school for medical records librarians; outstanding opportunity; progressive city; southwest. (b) Chief, 700-bed general hospital; college town; Michigan; to \$6200.

SUPERVISORS—(a) Operating room; 1000-bed leading progressive hospital; medical research center; also act as consultant, building program; \$7500; midwest. (b) Pediatric; 76-bed unit; research center; outstanding medical personnel; salary commensurate ability; university city, midwest. (c) Obstetrics; excellent opportunity; administrative ability; 50-bed unit; major hospital, vicinity New York City; better than average salary.

Our booth at the American Hospital Association Meeting is No. 311.

OUR 61st YEAR



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Medical Personnel Bureau
FORMERLY ALLENES
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CHICAGO • ILL.
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Telephone Randolph 6-5682

ADMINISTRATORS—(a) Medical; voluntary general JCAH hospital 450-beds; important teaching center; east. (b) FACHA capable taking over full range hospital administration, both medical and non-medical; 200-bed accredited general hospital; east. (c) 175-bed general teaching hospital registered FACHA able director 200-bed expansion; north west. (d) Medical or non-medical; 600-bed voluntary general teaching hospital; prefer FACHA; large Catholic community; city 120,000; attractive remuneration; midwest. (e) One able assist securing accreditation; new hospital 70-beds opening Fall '57; \$8-\$10,000; large university city; east. (f) Male or female; while experience necessary degree not required; new hospital 50-beds; \$8-\$10,000; middle Atlantic. (ff) Fully approved 200-bed general hospital requires M.H.A.; \$9000 plus lovely home; west.

(Continued on page 194)

WOODWARD—Continued

ASSISTANT ADMINISTRATORS—(g) To work directly under and report to FACHA; 1st year then assistant with own responsibilities; 200-bed voluntary general hospital; university town; New England. (h) Large voluntary general hospital; ideal for one well versed in all phases hospital relations; Ohio. (i) One experienced building maintenance, housekeeping, food service; general hospital expanding to 200-beds; university town; southwest.

DIRECTOR OF NURSES—(a) Nursing service & education; approved school, 75 students; MS preferred; 400-bed voluntary general hospital; \$10-\$11,000; east. (b) To work with Dean, nursing service only; college school, large university affiliated unit; requires superior administrator, experienced university hospitals; southwest.

MEDICAL PERSONNEL AGENCY

7 East 42nd Street
New York 17, N.Y.

ADMINISTRATORS—300 beds; east; expansion and building program; modern, progressive experience. (b) 250-beds east; present incumbent retiring. (c) R.N. Director, small nursing home, Up-state New York. (d) R.N. Director, home for aged, New York City.

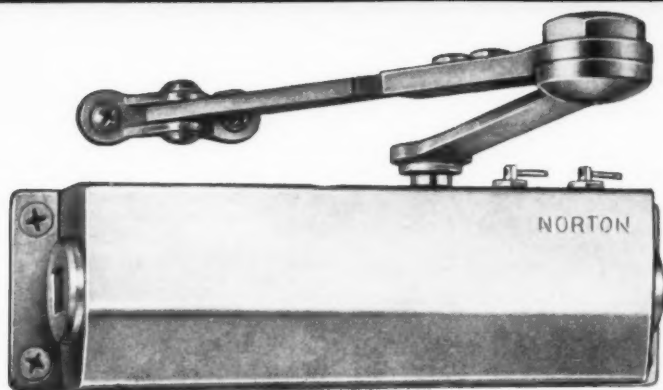
*We've moved
to new, larger and more
modern quarters on*

**REACH ROAD
WILLIAMSPORT, PENNA.**



ELECTRIC CORPORATION
Manufacturers of Physical Therapy Equipment

Announcing 2 More "Firsts" for NORTON DOOR CLOSERS!

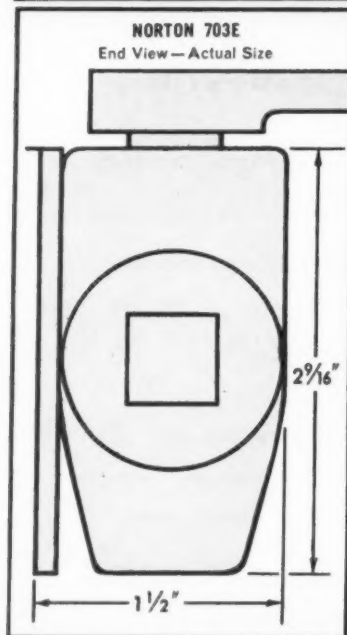
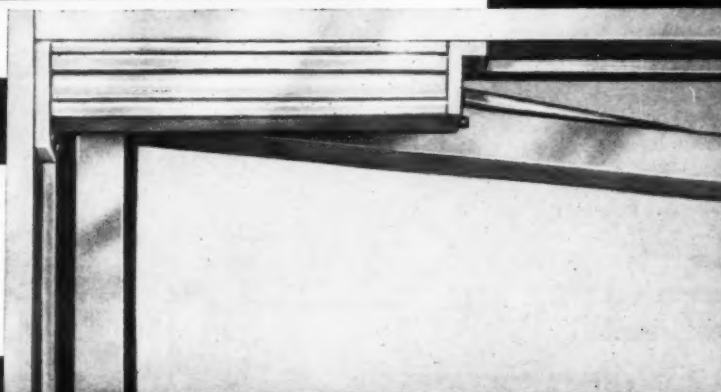


Norton 703E

Surface-mounted type...
First door closer ever made
with extruded aluminum
alloy shell.

Norton 750

Revolutionary corner de-
sign with concealed arms
and extruded aluminum
alloy shell.



Ultra-Modern in clean-lined functional design...Traditional in ruggedness
of construction...full rack and pinion dependability of operation.

After years of research to perfect suitable alloys and designs, Norton now offers the very first door closers which are not cast iron...not die cast or sand cast but *extruded from tough aluminum alloy* of such density that leakage through the shell is eliminated.

Utilizing this advance are two brand new Norton models specifically designed to complement the structural simplicity of modern doors...engineered to serve indefinitely with the efficiency, low maintenance and durability typical of all Norton Door Closers.

NORTON 703E: Surface mounted type, can be used on either side of door...only 1 1/2" projection...can be finished to match hardware...up to 180° opening, trim permitting.

NORTON 750: Corner type of unique design for outside doors...arms completely concealed when door is closed...blends unobtrusively with latest aluminum frame doors.

But, not all advantages of these newest Norton Closers can be listed here. Write today for new data sheets just off the press giving full description and specifications.

NORTON® DOOR CLOSERS

Dept. MH-97 • Berrien Springs, Michigan

classified advertising

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DIETITIANS—(a) Chief; California; 300-bed hospital; 55 employees in department. (b) Chief; northwest; 100-bed hospital in college town of 35,000; \$6000. (c) Therapeutic; middle west; 600-bed hospital; work in special diet kitchen; \$4800. (d) Chief; middle west; 50-bed hospital; \$5400. (e) Teaching; south; large hospital; \$4200. (f) Administrative; supervise entire food service including coffee shop in 260-bed teaching hospital; to \$6500. (g) Chief; middle east; 250-bed hospital soon to be 500; excellent opportunity; to start, \$5400. (h) Chief; east; 350-bed general hospital; to \$6000. (i) Traveling field dietitian; east; \$5000 plus traveling expenses.

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ADMINISTRATORS—(a) 400-bed western state hospital; Degree in Hospital Administration plus seven years experience required; large city; salary open. (b) 300-bed hospital; metropolitan area; Degree plus 8 years experience required; salary open. (c) 50-bed hospital; salary \$8,000; midwest. (d) 200-bed, New England hospital; salary \$8,500 to begin. (e) State hospital; midwest; salary \$10,000 per annum; Degree in Hospital Administration required.

ASSISTANT ADMINISTRATORS—(a) Large midwest hospital; background in personnel and public relations required; 400-bed hospital; salary \$8,500. (b) Assistant administrator; large New England hospital; background in

MEDICAL EMPLOYMENT—Continued

accounting required; salary open. (c) Assistant administrator; large State hospital; \$7,000 per annum to begin.

BUSINESS MANAGERS—(a) 300-bed Catholic hospital; Ohio; salary open. (b) 250-bed hospital; midwest state; salary open. (c) 100-bed hospital; Ohio. (d) 50-bed hospital; New England; \$8,500.

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(Continued on page 196)

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(Continued on page 198)

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(Continued on page 200)

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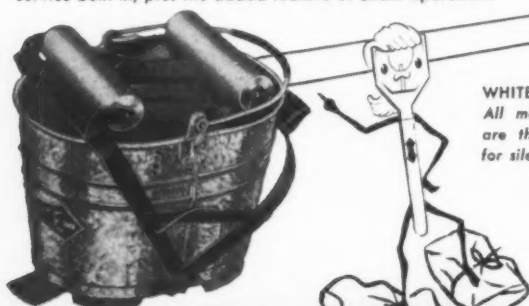
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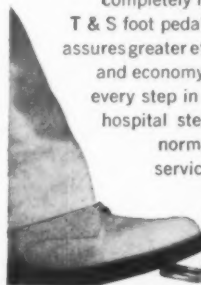
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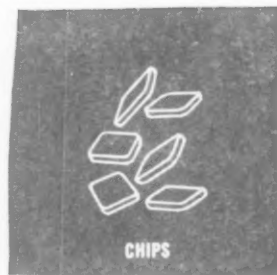
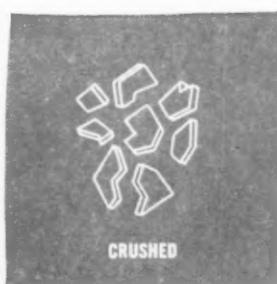
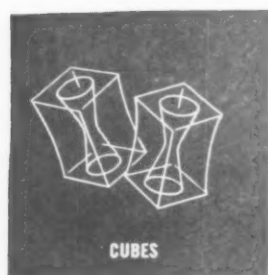
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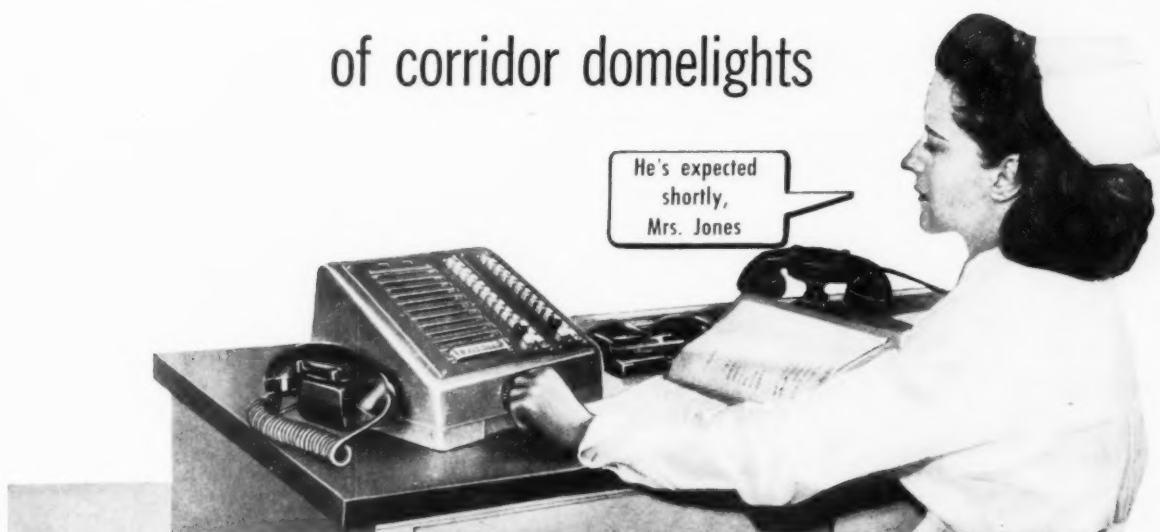
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In Canada: 331 Bartlett Avenue, Toronto

NOW AVAILABLE! THE FIRST STERILE STAINLESS-STEEL BLADE



New SteriSharps® can be autoclaved!

Eliminate messy solutions...blade waste!



PHOTO COURTESY WILMOT CASTLE CO.

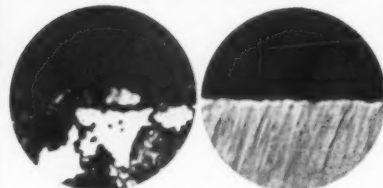
New stainless-steel SteriSharps — sharpest blades made — come individually sealed in foil, ultrasonically cleaned, ready for instant use. Save time, simplify technic in the OR.

SteriSharps are used only as needed — do away with the wasteful practice of preparing several blades for each operation. And SteriSharps can be autoclaved, just like other in-

struments so as to be instantly available to the suture nurse. Sealed packets can be re-autoclaved, stored indefinitely. Will not corrode.

Your supplier has SteriSharps in every design. And a stainless-steel dispenser is yours free with every five gross. Or write: A-S-R Hospital Division, Dept. MH, 380 Madison Avenue, New York 17, New York.

AUTOCLAVE TEST PROVES STERISHARPS SUPERIORITY



ORDINARY BLADE

STERISHARP

One of a series of tests which demonstrated the superiority of SteriSharps in hospital use subjected a SteriSharp and an ordinary surgical blade to autoclaving—under 18 pounds of pressure at 250 F.—for 30 minutes. The ordinary blade (left) was severely corroded and stained, and the edge became rough and impaired. The SteriSharp (right) did not corrode. The cutting edge was unaffected. Actual photos shown are magnified 1,000 times.



precision products

SteriSharps . . . the first sterile, stainless-steel surgical blade

WHAT'S NEW FOR HOSPITALS

SEPTEMBER 1957

Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 252. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Disposable Set for Transfusions

A bulb-shaped pump which permits instant control of the rate of fluid flow to



the patient is incorporated into the new Abbott disposable administration set for transfusions of blood, plasma or serum. The operator squeezes the bulb to administer a steady stream of fluid, and pressure exerted on the bulb determines the rate of flow. When the bulb is released, the fluid returns to drop administration at a predetermined rate. The administrator can easily observe the rate of drip or flow since the drop chamber does not flood. Safety features of the new pump include end of pressure when the bulb is released, a check valve to prevent withdrawal of blood from the patient, and placement of the filter to prevent pressure being applied to unfiltered blood. Abbott Laboratories, North Chicago, Ill.

For more details circle #368 on mailing card.

Diesel Electric Sets Have Compact Generator

The new, compact Caterpillar Generator is incorporated into each of three new mobile Diesel Electric Sets recently introduced. The highly mobile units, either skid-mounted or with running gear, include the D311 developing 30 KW of 60-cycle, three-phase current; the D315 rated at 40 KW, and the D318 at 60 KW. The output of their self-regulated, constant-voltage generators furnishes a choice of current. Control panels on the new sets are enclosed for safety of personnel and the set packages include all necessary equipment. Caterpillar Tractor Co., Peoria, Ill.

For more details circle #369 on mailing card.

Drymaster With Rinse Dry for Dishwashing Machines

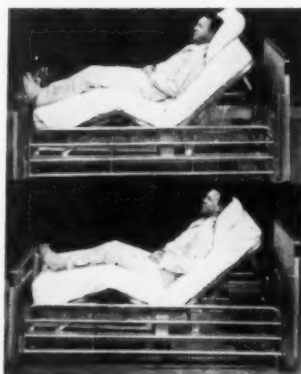
Drymaster is the name of a compact hydraulically powered instrument which becomes an integral part of the dish-

washing machine. With it a small but accurate volume of Rinse Dry is added to the final rinse water for sparkling dishes. Rinse Dry is a concentrated drying agent designed to dry glasses, silver, china and plasticware, without spots, in any dishwasher. Economics Laboratory, Inc., 250 Park Ave., New York 17.

For more details circle #370 on mailing card.

Extra-Length Spring for Tall Patients

More comfort and easier nursing care for tall patients are advantages of the new Simmons Extra-length L-229 Hospital Spring. The seven-foot long spring has a wider center section for more comfortable sitting posture and incorporates the Simmons standard two-crank opera-



tion. Simmons Hospital-Bilt mattress is available in seven-foot size to fit the new spring. The H-43 telescoping Safety Sides also extend to fit. Posture positions for every kind of treatment are easily obtained with the new spring which is available on all models of Single-Action Vari-Hite beds. Simmons Company, Merchandise Mart, Chicago 54.

For more details circle #371 on mailing card.

Ohio-Jet Humidifier Combines Dual Principle

Jet action is combined with bubble-through action for maximum humidity in the new Ohio-Jet Humidifier. With the new instrument the water is aspirated into an extremely fine fog which then bubbles through the surrounding water to produce additional humidification. High humidity is thus produced when operating either on normal pipeline

pressure or with a cylinder and regulator. A warning whistle is an added safety feature if oxygen delivery to the patient is obstructed. The new humidifier is obtainable in an unbreakable bottle of polyethylene plastic, clearly marked for water levels. It has high capacity and is easy to clean. Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.

For more details circle #372 on mailing card.

Ultra Speed X-Ray Camera Has Concentric Mirror Optics

The new Fairchild four by four camera with Concentric Mirror Optics is a versatile x-ray system. The films are small enough to make the camera practical for use in hospital admissions and mass chest surveys. The detail achieved makes it suitable also for general and serial diagnostic radiography.

The Bouwers Concentric Mirror Optical System incorporated into the camera gives it unusual speed, reducing patient exposure to x-rays. The increased resolution ensures sharp negatives of diagnostic quality. Much voluntary and involuntary motion is stopped because of the fast optical speed of the camera, reducing the necessity for retakes. The camera handles the four major categories of photofluorography. Fairchild Camera and Instrument Corp., Robbins Lane, Syosset, Long Island, N.Y.

For more details circle #373 on mailing card.

"Hot Pot" Beverage Server

A beverage server which nests conveniently in any style tea or coffee cup is offered in the "Hot Pot." It is designed to save space, prevent spillage and keep beverages hot in institutional tray

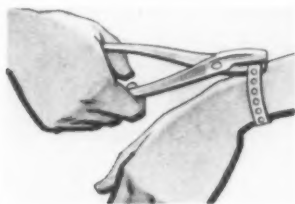


service. The "Hot Pot" is made in two styles, with sunken or knob cover, and is available in 26 colors. The Hall China Co., East Liverpool, Ohio.

For more details circle #374 on mailing card.

WHAT'S NEW

Shur-Lok Design for Identification Bracelet



The new Shur-Lok bracelet for patient identification is designed for use with older children and the mentally infirm

as well as other patients who may pose a problem. The Shur-Lok bracelet cannot be taken off or torn off. It is made from a new, tough, low-pressure polyethylene so strong that it cannot be weakened, stretched or broken, yet it is soft and comfortable. The bracelet is fastened by rosettes larger than normal with a special locking tip. There are no metal parts and the name bracelet can be assembled, fitted and applied in a few seconds with the new Shur-Lok Applicator, yet can only be taken off by cutting. **The Presco Company, Inc., 305 N. Church St., Hendersonville, N.C.**

For more details circle #375 on mailing card.

Curity Suture Reel for Suture and Ligating

The new Curity Suture Reel is designed for dual use. The same reel serves for suturing or ligating. The reel is held in the surgeon's palm just as it comes



from the packet, leaving his fingers free for work. Kinking of the suture is eliminated and a smooth, continuous flow of catgut is delivered. The new Suture and Ligating Reel requires no advance preparation and simplifies handling in the storeroom since one reel serves the dual purpose. Waste is reduced because of freedom from kinks and snarls. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #376 on mailing card.



So they may see...

Famous Castle illumination is now combined with the most maneuverable major surgical lamps ever built.

Without use of tracks or counterweights, Castle "60 Series" Lights provide new feathertouch mobility... permit instant control of light by the surgical team.

Fine adjustments are made in seconds... light beamed instantly where it is needed by those who actually see the result in the incision.

The result is proper and quicker light placement... faster, clearer, fatigue-free vision... better surgery.

Write for folder on Castle "60 Series" Lights and Color Camera Attachment.



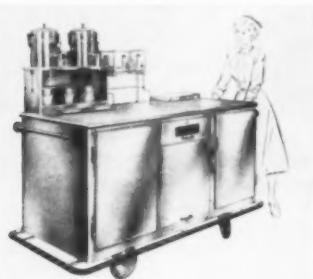
Castle

WILMOT CASTLE COMPANY
1700H East Henrietta Road • Rochester, N. Y.

LIGHTS AND STERILIZERS

Mobile Food Service in Diet Liner

A completely self-contained mobile food service unit is offered in the Diet Liner. A thermostatically controlled, mechanically refrigerated cold plate storage section, ice cream freezer and ice compartment, and an automatic, electrically heated hot plate storage section with temperature and humidity control as-



sure proper temperatures for food when served. Stainless steel hot soup or cereal containers are included as is a heated automatic cup and saucer dispenser.

The Diet Liner Model 57 has facilities for feeding 24 patients, including automatic toaster, individually heated and automatically controlled coffee and hot water urns and soiled dish and tray storage. Constructed of stainless steel inside and outside, the mobile unit is completely maneuverable and will turn in its own radius. It is 78 inches long and 35½ inches wide with a working height of 41 inches. **Diets Unlimited, Inc., 3000 Witte St., Philadelphia 34, Pa.**

For more details circle #377 on mailing card.

(Continued on page 212)



Does your Ethyl Alcohol supplier offer your Pharmacy all these advantages?

Dependable service from U.S.I.'s nationwide chain of bonded warehouses eliminates the need for excessive alcohol stocks, solves inventory and storage problems, is your most reliable source in case of emergency

The first requirement the pharmacist would set for ethyl alcohol is *purity*. But once the U.S.P. requirement is met (or exceeded, as it is with U.S.I. alcohol) he would add another qualification: *Service*.

Dependable delivery from a nearby source means the pharmacist doesn't have to keep excessive stocks on hand as a precaution against delayed deliveries. This in turn simplifies his inventory control records. His storage problems are

minimized, yet he knows that the once-in-a-million call for emergency supplies of alcohol will be answered . . . immediately.

U.S.I. offers that kind of service. America's oldest producer of hospital and industrial alcohol, U.S.I. has nine bonded warehouses across the country. Its sales organization has been serving hospitals for half a century.

For your pure alcohol needs, specify U.S.I. — get *purity and service*.



INDUSTRIAL CHEMICALS CO.

Division of National Distillers Products Corporation

99 Park Avenue, New York 16, N. Y.

Branches in principal cities

U.S.I. pure alcohol U.S.P. 

where Easy Maintenance counts—

This close-up of a 9' x 9' tile is typical of the beautiful, even marbling found only in Kentile Vinyl Asbestos Tile.

sturdy KENTILE® Vinyl Asbestos Tile is your best answer!

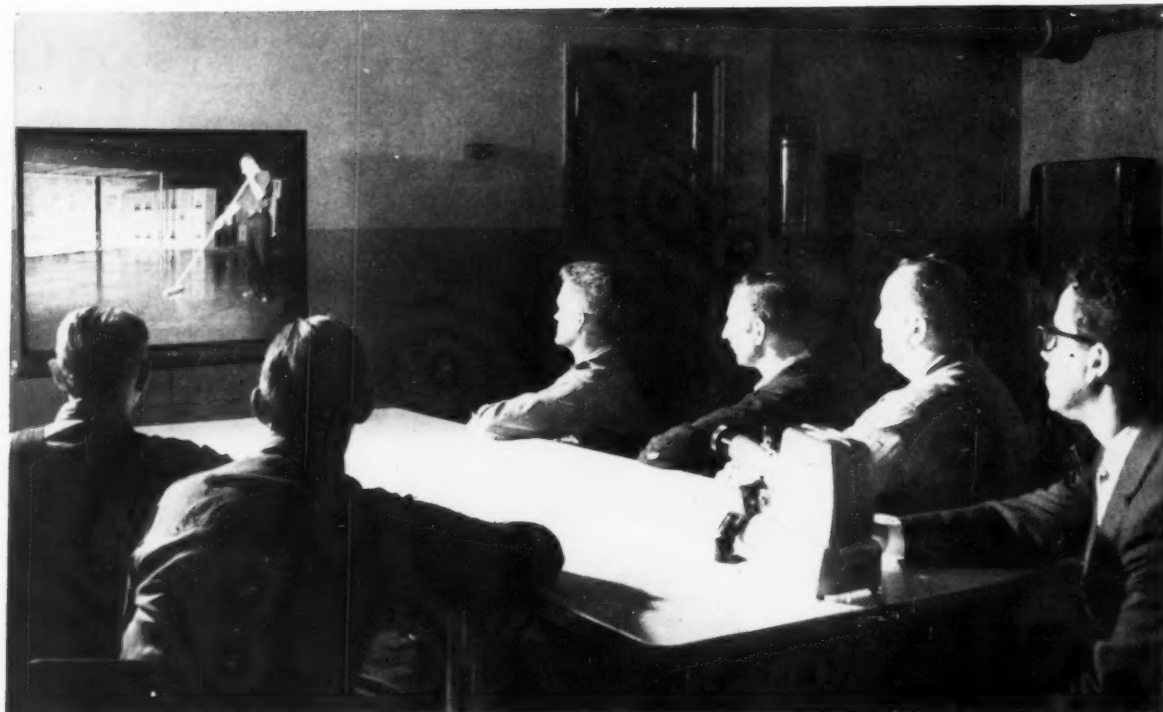
Durable vinyl! Tough asbestos fibers! They combine in Kentile Vinyl Asbestos Tile to give you the perfect flooring for hospital corridors, wards, and waiting rooms. The smooth, non-porous surface is greaseproof, marproof; withstands drugs and oils. Kentile Vinyl Asbestos Tile (KenFlex®) gives you lower maintenance costs because

minimum care keeps it clean and it is exceptionally long wearing. It's a better buy—even if the initial cost is slightly more than asphalt tile. And it can be installed over concrete in contact with the earth. Want more information? See your local Kentile flooring contractor, listed under FLOORS in your classified phone book.

KENTILE FLOORS

BROOKLYN 15, N. Y.

AVAILABLE IN • VINYL ASBESTOS • SOLID VINYL • CUSHION-BACK VINYL • CORK • RUBBER AND ASPHALT TILE . . . OVER 150 DECORATOR COLORS



They're learning scientific floor care



No uniformed ushers or popcorn for this audience . . . but the men who are viewing this film are here on mighty important business.

They're learning how to keep their floors more attractive with fewer gallons of material and fewer hours of time.

6 new floor maintenance films. In recent months, MULTI-CLEAN's Research Department has produced 6 new film strips illustrating scientific MULTI-CLEAN METHODS of floor care. These are titled:

- *Your Asphalt Tile Floor . . . Its Care and Maintenance*
- *The Treatment and Maintenance of Concrete Floors*
- *Installation, Finishing, and Maintenance of Gymnasium Floors*
- *Care and Maintenance of your Rubber Tile Floors*

- *Terrazzo and Oxychloride . . . and How to Maintain Them*
- *How to Care for Vinyl and Vinyl Asbestos Tile Floors*

Each film explains and illustrates the step-by-step METHOD for initial treatment, continued maintenance, and restoration of a particular type floor. They show the right materials, the right equipment, and the right technique.

Your men will enjoy the opportunity to increase their knowledge and improve their floor care technique by studying these films. Many ask for a second and third showing. "Best we've ever seen," they tell us.

Arrange free showing. Give your maintenance personnel the opportunity to see these free training films. Just fill in and mail the coupon . . . or call your local MULTI-CLEAN Distributor today. You'll be under no obligation whatsoever.

MULTI-CLEAN

Method

The combination of the right Multi-Clean Equipment and Materials with the correct procedure.

MULTI-CLEAN PRODUCTS, INC., Dept. MH-58-97
St. Paul 16, Minnesota

I'd like to arrange for my staff to view films on MULTI-CLEAN METHOD of care for these floors:

- | | | |
|---------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Asphalt Tile | <input type="checkbox"/> Gym Floors | <input type="checkbox"/> Terrazzo |
| <input type="checkbox"/> Concrete | <input type="checkbox"/> Rubber Tile | <input type="checkbox"/> Vinyl Tile |

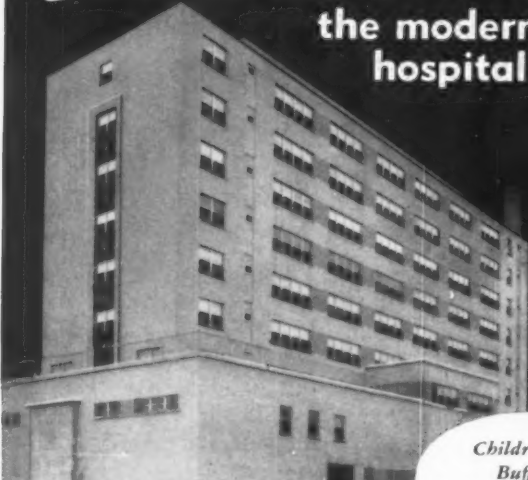
Name

Address

City Zone State

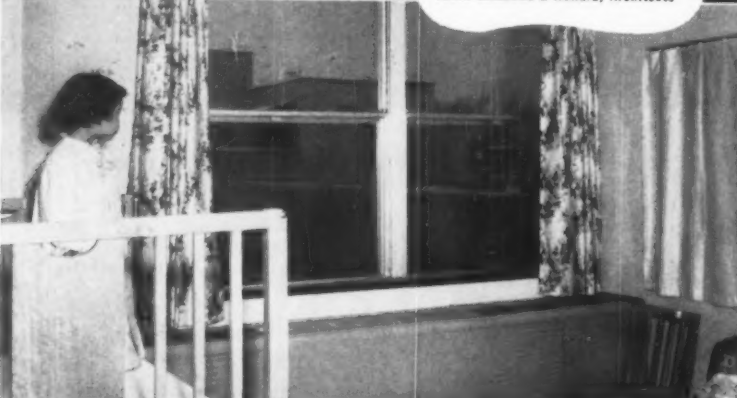
WHAT'S NEW

Fleetlite Windows
the modern
hospital treatment



- Provides the right ventilation for any weather condition.
- Improves nursing and hospital morale.
- Adds years of maintenance—free life to buildings.

*Children's Hospital
Buffalo, N. Y.
James Meadows & Howard; Architects*



The tight weatherstripped and interlocking construction of Fleetlite windows stops drafts, dust, noise, rain and snow for extra comfort. Double window design provides the insulating air space that saves heating and air conditioning costs and permits indirect ventilation during rainstorms. Fleetlite windows never need painting or puttying. Save maintenance costs.

Other Fleetlite products of comparable high quality include Double Horizontal Sliding Windows, Sliding Glass Doors, Jalousie Windows and Doors.

*All sash easily
removable from
the inside for
cleaning.*



Fleetlite
AMERICA'S finest WINDOW

**FLEET OF AMERICA
INCORPORATED**

1951 WALDEN AVENUE
BUFFALO 25, NEW YORK

Manufacturing Aluminum Windows Since 1926

☐ Send me complete information on Fleetlite windows.

☐ Please have a representative call.

Name.....

Address.....

City.....Zone.....State.....

Patient Gown

Has Extra Length

The new "Forty-Fiver" Patient Gown developed by Angelica is 45 inches long.



has no side seams to rip, yet the patient may lie in any position with no bulk to irritate the skin. Extra wide short sleeves facilitate examination and injections while providing patient comfort. The gown is made of Angelica Dura-cloth, a lightweight, high-count percale which is soft and comfortable, yet will withstand repeated launderings. Angelica Uniform Co., 1427 Olive St., St. Louis 3, Mo.

For more details circle #378 on mailing card.

Motorized Traction With Duo-Trac

Motorized intermittent traction in any direction, from horizontal to vertical or any angle in between, can be applied with the new Duo-Trac. The mobile instrument can be rolled up to bed, chair or table for treatment and the comfortable

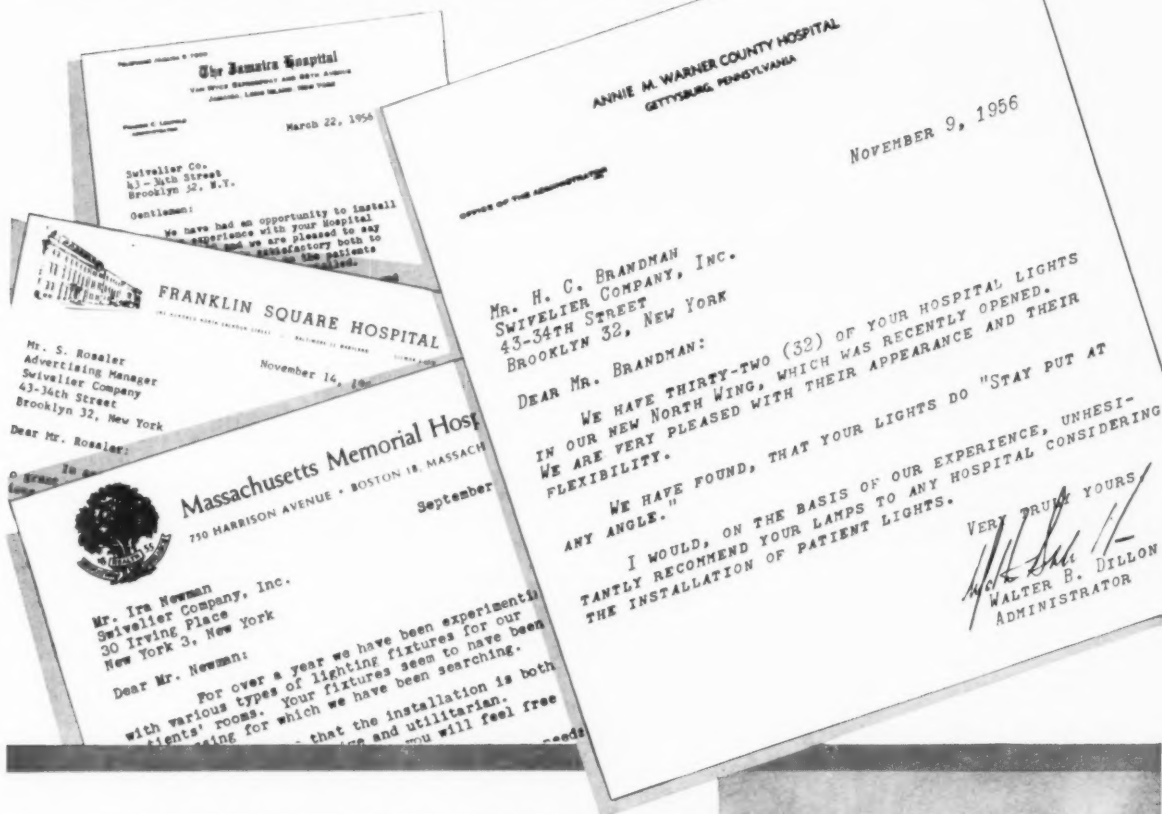


harness is designed to fit any part of the body. The patient can control the amount of pull up to five inches, and can stop the intermittent or constant traction at any time. Three rubber tired wheels make the Duo-Trac easy to move about the hospital and it can be used at the x-ray table or in the operating room where traction is needed in orthopedic work. Stanley Physical Therapy Equipment & Supply Co., 175 N. Wabash Ave., Chicago 1.

For more details circle #379 on mailing card.

(Continued on page 214)

Love Letters ♥♥♥



With SWIVELIER HOSPITAL-LITES, it's usually a case of love at first light!

Hospital administrators, engineers, architects cherish our patented Swivelier spring-tension Socket—adjusts to any position, will not drop down. They adore our Swivelier-Coolite Shade (prevents burns, protects patients, physicians, nurses) and Swivelier's superior mounting and assembly features which keep maintenance at an irreducible minimum. Unanimously, they go for our wide choice of models—for wall, bed, floor and laboratory.

Leading hospitals have been sold on Swivelier superiority by their own tests. You can do the same. Write Dep't. MH9 for full information (and complete catalog) today.

SWIVELIER HOSPITAL-LITES USED AND APPROVED BY

UNIV. of CALIF. MEDICAL CENTER, L.A.
JOHNS HOPKINS UNIV. HOSPITAL, Balt.
V.A. HOSPITAL, Grand Island, Neb.

TEMPLE UNIVERSITY HOSPITAL, Phila.
HENRY FORD HOSPITAL, Detroit
STE. JUSTINE HOSPITAL, Montreal

....and many other hospitals



LOOK FOR THE SWIVELIER TRADEMARK

Underwriters Laboratories, Inc. approved

swivelier
COMPANY, INC.

43-34 STREET, BROOKLYN 32, N.Y.

SALES OFFICE & SHOWROOM: 30 Irving Place, New York 3, N. Y.
In Canada: Verd-A-Ray Electric Prod. Ltd. Montreal

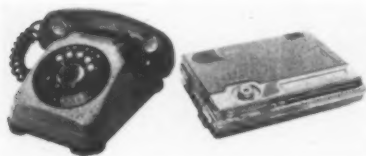
AGENTS AND DISTRIBUTORS THROUGHOUT THE WORLD

See Swivelier Hospital-Lites Booth No. 831, A.H.A. Convention

WHAT'S NEW

All-Purpose Voicewriter Is Versatile Dictating Unit

Dictation for every need as well as transcription can be accomplished with



the new Edison All-Purpose Voicewriter. Different sets of accessories are simply plugged in for the various re-

quirements. The all-purpose machine will record dictation at the desk, in conferences or while traveling, and the same machine with different attachments permits transcription of the dictation.

By plugging a small control box into the all-purpose unit and hooking it up with the dial telephone system of an institution, as many as 20 persons can dictate by remote control. A different control box permits dictation from Edison-made dictating phones. The versatile new unit provides dictating facilities for practically every need. **Thomas A. Edison Industries, West Orange, N.J.**
For more details circle #380 on mailing card.

Dri-Hot Plate Facilitates Hot Food Service

A special cast alloy Dri-Hot disc is heated in a 450-degree oven for 15 minutes to keep food hot until served in the Dri-Hot Plate. The heated disc is placed in the stainless steel plate holder, the china plate with the complete hot meal



assembled is put in the holder and covered with the stainless steel cover. Food is kept hot and tempting in the unit for as long as an hour and a half, according to the report. **Legion Utensils Co., 40th Ave. & 21st St., Long Island City 1, N. Y.**
For more details circle #381 on mailing card.

MISS PHOEBE

NO. 19 IN A SERIES



"... so I said, Let's just see if it can out maneuver an E&J!"



Maneuverability means easier handling—one of the reasons both patients and hospital personnel prefer E&J chairs. But even dearer to hospital hearts and budgets is the fact that E&J chairs require little or no maintenance—they practically refuse to wear out. Over the years they prove to be your most economical buy.



Specify **EVEREST & JENNINGS** chairs
for your hospital

EVEREST & JENNINGS, INC., 1803 PONTIUS AVE., LOS ANGELES 25 CALIF.

Hot Drink Handle Cup in China-Cote Quality

A new China-Cote handle cup for hot drinks is now available from Lily-Tulip. Made in the standard China-Cote Big Leaf design in a dark green color, the new handle cup is offered in six and eight-ounce sizes. The China-Cote strength and rigidity make the cup ideal for all feeding operations. **Lily-Tulip Cup Corp., 122 E. 42nd St., New York 17.**
For more details circle #382 on mailing card.

Sanitary Napkins in Compact Form

A full-sized external sanitary napkin is now available compressed into a small



compact blue tube only slightly larger than a lipstick case. The superior quality highly-absorbent napkin fluffs out to original softness and size when removed from the easily-opened tube. The "Delicate" napkin is dispensed through a special machine. The compact size of the napkin permits loading a large number into the dispenser. **American Hygienic Corp., 209 S. La Salle St., Chicago 4.**
For more details circle #383 on mailing card.

(Continued on page 216)

*When you choose
an infant incubator,
consider*

4 facts of life

In incubator care of the small premature infant . . .
. . . the ill premature infant . . . the infant requiring isolation

The ISOLETTE, only "completely air-conditioned" infant incubator described and illustrated in the new 2nd edition of "Premature Infants," may serve also as "an isolation unit in addition to maintaining optimal environmental conditions, and is particularly useful in caring for the smallest infants."*

Many infant incubators now look like the ISOLETTE, but sell for less. Therefore, we recently engaged a well-known, independent laboratory to compare control of temperature, humidity, and oxygen in every infant incubator on the market. We'll be glad to mail you the 22-page report of this objective comparison study. Or you can make your own tests of ISOLETTE performance with any other incubators. If you're not satisfied in 30 days, return the ISOLETTE to us, express collect, and discard your invoice.

For value, choose the ISOLETTE. It is designed to perform, built to last. We have never had to replace a worn-out ISOLETTE. Phone us collect (OSborne 5-5200, Hatboro, Pa.) and order an ISOLETTE with our 30-day return privilege. Test it. Pay only if satisfied. But don't let appearance or initial cost mislead you: let *performance* guide your choice.

The
Isolette®

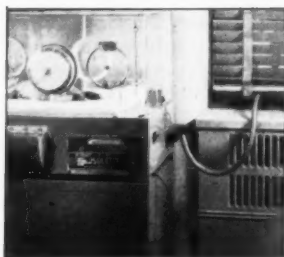
Constant-fresh-air-flow infant incubator

first in its field . . . widely copied . . . never equalled

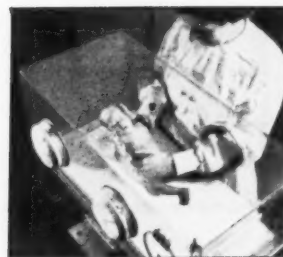
Designed, Manufactured, Sold and Serviced by

AIR-SHIELDS, INC.

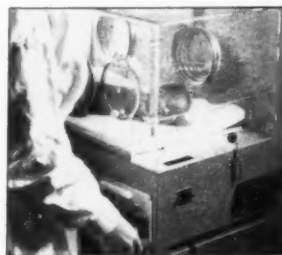
Hatboro, Pa.



1. True Isolation: Only the ISOLETTE® continuously draws in fresh, pathogen-free air from outside the nursery, forces out used air, protects the infant from air-borne or droplet infection. The ISOLETTE completely replaces incubator air every 15 minutes, approximately.



2. Constant Circulation of Fresh, Warm Air: The ISOLETTE alone provides a continuous supply of clean, fresh air, with precise control of warmth, humidity, and extra oxygen (when needed)—features impossible to achieve without controlled, mechanical air circulation.



3. Precise Temperature Control: Within a tolerance of 1°F., plus an automatic alarm should external factors cause overheating, is another unique advantage of the ISOLETTE, which may also be cooled to 85°F. in very hot weather.



4. Accurate Humidity Regulation: An additional, exclusive distinction of the ISOLETTE, maintains even, optimal humidity levels (85% to 100%) by means of a simple, calibrated valve, and quite independent of temperature.

*Dunham, E.C.: *Premature Infants*, 2nd Ed., Hoeber-Harper, New York, 1955

WHAT'S NEW

from COMMUNITY

new
ideas
in

hospital
furniture

CREATED
TO MEET
THE DEMAND

SPACE
SAVING
BEDSIDE
CABINET



the "COMBINETTE"

With
many new
features
including

- ★ Drawers at all heights for High-Low beds.
- ★ Compartment holds bed pan, urinal and wash basin.
- ★ More drawer space.
- ★ Como-Lite plastic tops.
- ★ Accessory cabinet for treatment rooms.

Write for New, Illustrated, Informative Catalog of the Complete Community Line.

SERVING THE NEEDS OF
HOSPITALS FOR 21 YEARS

**COMMUNITY METAL
PRODUCTS CORP.**

1213 Circle Avenue
Forest Park, Illinois

Restyled Copy Machine Is Lightweight and Compact

The Thermo-Fax "Secretary" copying machine has been redesigned for lighter



weight and more compact size. The restyled cabinet design has push-button controls to produce copies in an all-electric, completely dry, one-step process. Exact copies can be made of correspondence, records, forms and other administrative papers in a matter of seconds. The new step-front cabinet provides a working area and permits easier entry of paper into the machine. The unit fits conveniently on office desks or filing cabinets. Minnesota Mining & Mfg. Co., 900 Bush St., St. Paul 6, Minn.

For more details circle #384 on mailing card.

Riding Mower Turns "On a Dime"

The new Jari Square-Turn PowerRide Mower features an exclusive transmission that permits it to be turned in minimum space. Fiber glass is used for the arm-chair type seat on the new riding mower which has a streamlined body. Designed



for institutional use, the new machine cuts a 30-inch path with the front reel only, or a 66-inch path with two wing units added. A choice of either 3.3 or 6.8 h.p. motor permits use of the mower for any grass-cutting need. Jari Products, Inc., 2990 Pillsbury Ave., S., Minneapolis 8, Minn.

For more details circle #385 on mailing card.

Prepared Swabs for External Antisepsis

The new Grafco Redi-Asepti Swabs are saturated with Cetylamine, ready for use in external antisepsis. They are made of finely spun staple cotton, uniform in size and shape, firm and compact. The solution used is non-toxic, odorless and non-irritating. Graham-Field, Woodside 77, N.Y.

For more details circle #386 on mailing card.

(Continued on page 219)

IN MEMORY OF
FRED C. BECKER
BY HIS FAMILY

BRONZE TABLETS

in any size, for any purpose:

Desk and Door Plates
Memorial Tablets
Signs • Donor Tablets
Add-a-Name Plaques
Portrait Tablets

Write for Illustrated Catalogs



MEIER JOHAN-WENGLER

1102 W. 10th St. CINCINNATI 2, OHIO



ORNAMENTAL LIGHTING FIXTURES

of
Wrought Iron,
Ornamental
Bronze
and
Aluminum.

Write for our profusely illustrated catalog, showing scores of designs, both simple and ornate. No job too small, none too large.



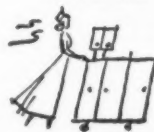
There are no more finicky eaters in the world than hospital patients. Nothing does more for a patient's morale than a pleasantly served, appetizing meal. And that's what you serve, every time, with Meals-on-Wheels System.

Meals-on-Wheels proved best by taste tests in hospitals* all over the nation... proved more economical by hospital administrators all over the nation.

*List available without obligation.

Write for full details to:

**Meals-on-Wheels
System**



Dept. 11,
5001 E. 59th St.
Kansas City 30,
Missouri

"See us at Booth 721 AHA Convention"

New nursery equipment?

...YOU'LL WANT THIS!

SEND FOR THIS USEFUL FREE BROCHURE TODAY

A. S. ALOE COMPANY
1831 Olive St., St. Louis 3, Mo.

Please send Nursery Equipment Brochure.

Name

Hospital

Street

City and Zone State

Prepared by recognized specialists in equipment selection for the modern nursery. Itemizes equipment for both nursery and formula rooms. Lists and illustrates with diagrams and floor plans every piece of equipment you'll need to modernize your nursery. Gives minimum equipment requirements; describes desirable features of recommended units. To request your copy just fill out and return coupon above or jot a note on your hospital letterhead.

See latest Nursery Equipment in Aloe Booth 613, AHA Convention

A. S. ALOE COMPANY — BETTER HOSPITAL EQUIPMENT FOR BETTER HOSPITAL CARE
1831 OLIVE STREET, ST. LOUIS 3, MISSOURI • LOS ANGELES • PHOENIX • SAN FRANCISCO • SEATTLE • DENVER • MINNEAPOLIS
KANSAS CITY • DALLAS • NEW ORLEANS • ATLANTA • MIAMI • WASHINGTON, D. C.



weeks?

months?

years?

Improve the prognosis in fractures with
"Premarin" with Methyltestosterone

Healing of fractures is often delayed because impairment of osteoblastic activity due to declining sex hormone function causes the bone matrix to atrophy.

Older patients with fractures, particularly of the hip, respond well to combined estrogen-androgen therapy. The prognosis for bone recalcification is good provided treatment is continued for extended periods.*

*Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2, New York, The Blakiston Company, Inc., 1954, chap. 98, pp. 702, 703.

"PREMARIN"® with METHYLTESTOSTERONE

Excellent preparation for estrogen-androgen therapy

Ayerst Laboratories • New York, N. Y. • Montreal, Canada



5647

WHAT'S NEW

Folding Lectern Is Portable



Designed to fill the need for lecterns in widely separated places, Detroit Lectern has introduced the new "Executive" Portable Lectern. The unit unfolds for instant use and folds for convenient storage or carrying from place to place. It is lightweight and sturdily constructed. The reading surface is comfortably inclined and available accessories include lamp and carrying case. Detroit Lectern Co., Inc., P.O. Box 3735, Detroit 15, Mich.

For more details circle #387 on mailing card.

Air Deodorant Is Highly Effective

Hospital Air Deodorant (HAD) is a newly developed product, one drop of which is said to completely deodorize and neutralize the air in a room of 1000 cubic feet for more than 24 hours. The result of research to eliminate odors emanating from dressings and bed clothes of skin cancer patients, HAD is a highly concentrated, non-toxic and non-irritating formula. Tests indicate that one drop of HAD placed on a bit of tissue, cotton, cloth or absorbent paper near the source of odors neutralizes them within one minute. Tests were made under severe conditions in sick rooms, washrooms, animal laboratories, operating rooms, and for the control of fetid and personal odors, cooking odors, stale smoke and the like. S. M. Edison Chemical Co., 2710 South Pkwy., Chicago 16.

For more details circle #388 on mailing card.

Plate Glass Door Is Ruggedly Constructed

The new Pittsburgh plate glass door, known as the West Tension Door, is engineered with a piece of one-half inch thick glass held under compression by a thin metal frame. This design offers structural strength which is durable and impact resistant and will not sag, rack or

get out of alignment. It offers many design possibilities as locks and accessories are interchangeable and many combinations of pull or push plate type door handles can be used. The West Tension Door is particularly suitable for operation with any automatic opening device and may be adapted to overhead closes, center mounted or offset



mounted, and can be furnished with offset built-in hinges. The unit is offered in rough or polished plate glass. Pittsburgh Plate Glass Co., 632 Ft. Duquesne Blvd., Pittsburgh 22, Pa.

For more details circle #389 on mailing card.

(Continued on page 222)

Have you seen America's Outstanding Space-Saving Filing System?



"The System that Makes
Shelf Filing Practical!"

The Only
Filing System

- With and without easily operated Drop Doors!
- Units from 7 to 10 openings



Typical
Visi-Shelf Hospital Installation

SEND COUPON TODAY FOR FULL DETAILS OF THE VISI-SHELF FILING SYSTEM

VISI-SHELF FILE INC.

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New York 7, N. Y.

Visi-Shelf File, Inc.
225 Broadway
New York 7, N. Y.

34

Please send free catalog describing the new Visi-Shelf Filing System for Medical Records and X-Ray Negatives.

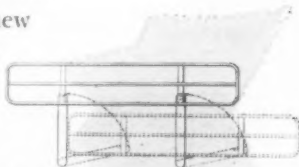
Name _____
Address _____
City _____ Zone _____ State _____

WHAT ARE YOU DOING ABOUT YOUR SAFETY SIDE PROBLEM?



A COMPLETELY NEW, PROVED-IN-USE, SAFETY SIDE PRINCIPLE

Royal Universal Safety Sides operate on an entirely new principle . . . Brackets attach to side rail of the spring and serve as centers about which supporting arms pivot when sides are raised or lowered.



- ① **Fits any hospital bed spring . . . completely interchangeable.**
By simply installing brackets on each bed spring, Universal Safety Sides can be moved from bed to bed without tools.
- ② **Completely out of the way when lowered.**
Eliminates any obstacles in making beds or treating patients—flush with spring fabric when lowered.
- ③ **Locks automatically and securely when raised.**
Simple spring release makes raising and lowering almost effortless.
- ④ **No interference with orthopedic devices—bedside tables—footstools or steps.**
. . . Even on Hi-Lo beds, no risk of damage to walls or bed ends—no chance of injuring personnel or patients.



ROYAL METAL MANUFACTURING COMPANY
1 Park Avenue, New York 16, N.Y., Dept. 8-J

Please send literature on Universal Safety Sides.

Individual _____
Institution _____
Street _____
City, Zone, State _____

IN HOSPITALS

Hanovia Equipment

LUXOR ALPINE QUARTZ LAMP



Delivers complete ultraviolet spectrum. Provides intense radiation of wide, even distribution.

SUPER ALPINE QUARTZ LAMP



Powerful, high intensity quartz mercury arc emits all effective intense bands of therapeutic ultraviolet.

AERO-KROMAYER QUARTZ LAMP



Intense, concentrated source of ultraviolet for local and official application. Air cooled!

proving high clinical value of ultraviolet therapy in treatment of all these diseases and conditions:

Physical Rehabilitation: Ultraviolet is particularly effective in increasing blood hemoglobin level. Authoritative report reads: "The blood changes produced by ultraviolet radiation are increased number of red and white cells and platelets, lowered blood sugar, increased sugar tolerance, increased blood calcium, relative lymphocytosis and eosinophilia." Other authorities state: "Ultraviolet exerts a glycogen storing effect preventing the lowering of respiratory quotients after muscular exercise." Exposure to Hanovia ultraviolet improves absorption and utilization of calcium, iron, nitrogen and phosphorus.

Tuberculosis: Irradiation is of distinct value for patients suffering from tuberculosis of the bones, articulations, peritoneum, intestine, larynx, and lymph nodes, or from tuberculosis sinuses.

Care of Infants and Children: The prophylactic and curative effects of ultraviolet radiation on rickets, infantile tetany or spas-

mophilia, and osteomalacia are well known.

Psoriasis: Goeckerman technique, crude tar and ultraviolet radiation, very helpful in numerous cases. Ultraviolet produces definite chemical change in tar, a combination both reliable and effective.

Other applications include treatment of numerous skin diseases, with ultraviolet radiation acting specifically on lupus vulgaris, and providing a beneficial effect in such conditions as acne vulgaris, pityriasis rosea, indolent ulcers, and some forms of eczema.

Yours on request: Authoritative treatises describing ultraviolet therapy. Write for your free copies today. Dept. MH-9.

HANOVIA GREATEST NAME
IN ULTRAVIOLET

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The MODERN HOSPITAL

FORT HOWARD'S

Palmer

TISSUE

... Good-will builder in the washroom

Pure white, soft, absorbent Palmer Tissue—the finest 1000 sheet roll obtainable for institutions and industry—provides the quality and gentleness of home tissue.

This gentle absorbency—in every Palmer sheet—pleases all your employees, customers or visitors. Result—good-will for you.

Isn't it time to re-examine your tissue needs? Remember—your requirements can be met better by Palmer . . . or another of Fort Howard's 19 grades and folds. For more information and samples, call your Fort Howard distributor or write Fort Howard Paper Company, Green Bay, Wisconsin.



Fort Howard Paper Company

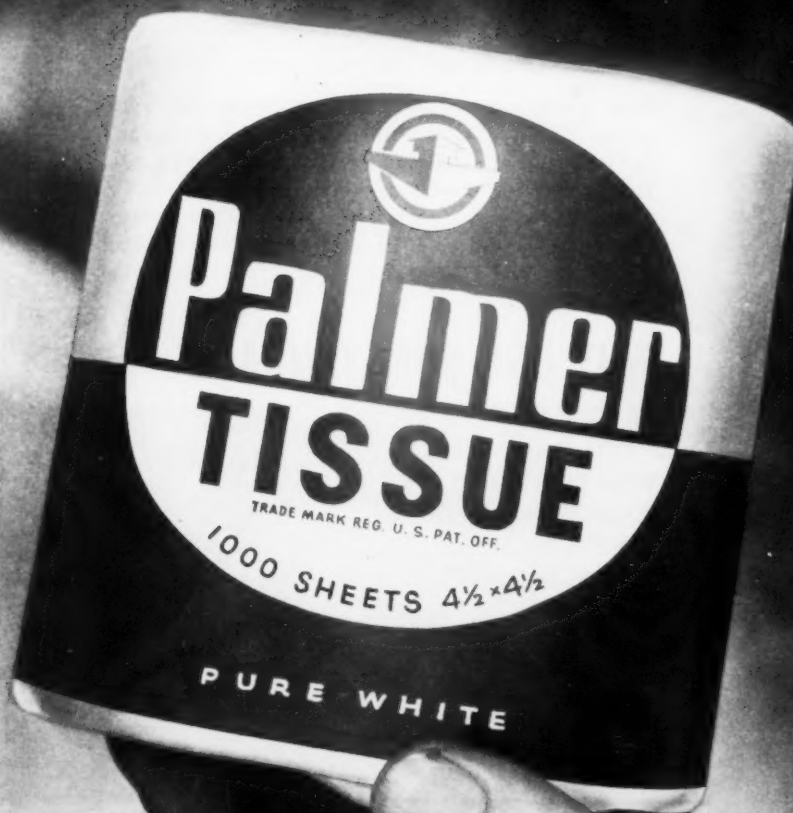
Green Bay, Wisconsin

America's most complete line of paper towels, tissues and napkins.

HS-135

©Fort Howard Paper Company

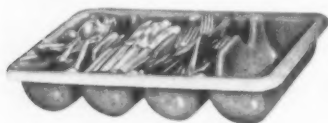
*"Little things affect peoples'
attitude toward you"*



WHAT'S NEW

Cutlery Box Constructed for Hard Wear

The new Don Royalite Cutlery Box is molded of a rubber-plastic composition



to withstand heavy-duty use in schools, hospitals and other institutions. It will not dent, crack, chip or peel and resists acids, alkalies, grease and stains. Its

rounded corners eliminate dirt-catching seams. The box is finished in gray and has sure-grip rims for easy handling. **Edward Don & Company, 2201 S. La Salle St., Chicago 16.**

For more details circle #390 on mailing card.

Fresh Frozen Fish in Fillet-Cut Portion

The eye and appetite appeal of fresh fish is offered in the new frozen "Fillet-Cut Portion" Fish. Developed after two years of research, the new fillet shape has the appearance of a fresh fillet, yet is a

uniform cut for precise portion control. Exact costs can thus be recorded with the new pre-breaded frozen fillets.

Made of choice skinless and boneless cod or haddock fillets, the new units are packed twenty portions to a five pound



VASELINE® PETROLATUM GAUZE

conforms fully to the official
standards prescribed by the U.S.P.

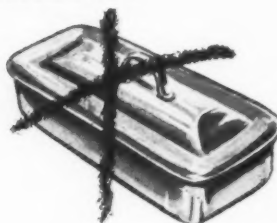
This prepacked, pretested material assures unquestionable sterility at time of use.

Especially-designed equipment impregnates the gauze so lightly and uniformly that the danger of maceration is minimized.

Most hospitals are neither staffed nor equipped to follow the U.S.P. XV specifications for the preparation and control testing of a dependably sterile petrolatum gauze. That is why 'Vaseline' Sterile Petrolatum Gauze U.S.P. is their choice of a nonadherent dressing. It has proved itself "best by test" in millions of cases in thousands of civilian as well as military hospitals throughout the United States.

WHY USE SUBSTANDARD MATERIAL

when this superior
prepacked sterile product
is available at a
worthwhile saving?



CHESEBROUGH-POND'S INC.
Professional Products Division
NEW YORK 17, N.Y.

VASELINE is a registered trademark of Chesebrough-Pond's Inc.

box and weigh exactly four ounces each. **O'Donnell-Usen Fisheries, 1 Fish Pier, Boston 10, Mass.**

For more details circle #391 on mailing card.

Custom Ceiling Lighting in Standard Package

The new Sylvania Sylva-Lume Lighting System permits a wide variety of custom designs from a few standard parts. It is a modular, interchangeable plastic panel system which offers many design patterns through color, form, texture and style. Design is achieved through three styles of diffusing panels; shallow, deep and drumhead (illustrated), each with color variations, plus a three-foot long Acoustic Baffle in three colors. Baffles can be used to frame panels or run in rows lengthwise or crosswise



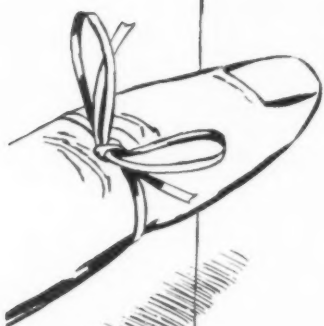
between panels. Other major elements making up the Sylva-Lume system include perimeter panels, track system and the new "Outrigger" fixture. **Sylvania Electric Products Inc., One 48th St., Wheeling, West Va.**

For more details circle #392 on mailing card.

Concentrated Bactine in Gallon Size

Concentrated Bactine is now available in gallon sized containers for hospital use. Eight gallons of standard strength Bactine antiseptic are made from one gallon of the concentrated product. Concentrated Bactine remains available in pint bottles in addition to the new economical hospital size. **Miles Laboratories, Inc., 1127 Myrtle St., Elkhart, Ind.**

For more details circle #393 on mailing card.
(Continued on page 224)



The Name to Remember **RIB-BACK**

To the Profession it has served with undivided responsibility for so many years . . . BARD-PARKER has devoted its scientific knowledge and the inimitable skill of its craftsmen in developing the finest surgical blade possible . . . a blade that meets the demand of the Profession for quality and economy.

The satisfaction of knowing you have chosen the best is yours when you use B-P RIB-BACK blades.

It's Sharp

Ask your dealer

BARD-PARKER COMPANY, INC.
Danbury, Connecticut

UNIFORMLY SHARP

**RIGID
STRONG**

the 'only' RIB-BACK BLADE



Sanitation

that Pays for itself



No Scavenger Service



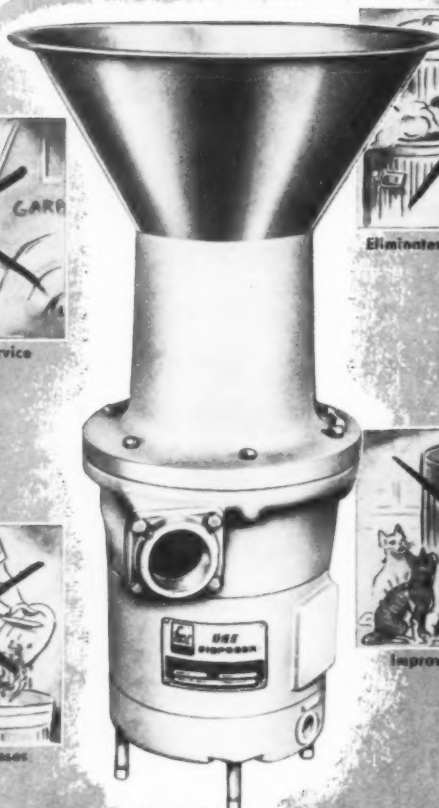
Eliminates Garbage Storage



Reduces Silver Losses



Improves Sanitation



JET DISPOSER

The modern space and labor saving way to dispose of kitchen food waste. The JET easily handles bones, corn cobs, celery, milk cartons, paper napkins . . . even rags and string. Exclusive principle of design breaks, pulverizes, liquefies all food waste. Power requirements and maintenance costs reduced to a minimum. Write for data and testimonial brochure.



Automation
equipment for kitchens

Kitchen Equipment Department

FOOD MACHINERY AND CHEMICAL CORPORATION

General Sales Offices: P. O. Box 1120 6 N. Michigan 103 E. Maple Street
San Jose 9, California Chicago 2, Illinois Hoopston, Illinois

WHAT'S NEW

X-Ray Film Illuminator for Non-Hazardous Areas

The new NXFI non-explosion proof X-Ray Film Illuminator features light-



weight construction, versatility and low initial cost for installation in non-hazardous areas. It may be mounted above the five-foot level in operating rooms in accordance with safety regulations. Full, shadowless view of the film is offered in the versatile illuminator which may be mounted in single, double or unlimited banking. It may also be mounted on a cart for ready mobility in ward use. The NXFI is adaptable for flush, surface or portable mounting. Appleton Electric Co., 1743 Wellington Ave., Chicago 13.

For more details circle #394 on mailing card.

Hydraulic Chair Lifts Patient for Bath

The Dalton Portable Hydraulic Bath Chair Lift is designed to lift bedridden and wheelchair patients into and out of the bathtub. The patient slides from the chair onto the seat of the lift, the seat



is swung over the tub and a push of a button lowers the waterproof seat, with the patient, into the tub. When the bath is finished, a push on the button raises the seat to the top of the tub where the patient moves back onto the wheelchair seat.

The Bath Chair Lift is constructed of high grade steel tubing with all parts chrome plated or anodized. Seat covers are of porous vinyl plastic, tailored to fit and easily installed by means of zippers. The lift is designed to fit any standard bathtub. Dalton Mfg. Co., 6511 S. Rosemead Blvd., Rivera, Calif.

For more details circle #395 on mailing card.
(Continued on page 226)

The MODERN HOSPITAL

Libbey Heat-Treated DATED Glassware

"is a real money-saver in our restaurants"

Hayes-Bickford Lunch System Inc.
32 GARRISON STREET

Boston Massachusetts
TELEPHONE COMMONWEALTH 8-9122

Libbey Glass
Division of Owens-Illinois
Toledo 1, Ohio

Gentlemen:

In our 17 Hayes-Bickford restaurants we have used Libbey Heat-Treated DATED Glassware for many years, with complete satisfaction.

Yet we were amazed when we made our own survey to find the actual servings each tumbler produced. Using the code symbol on every glass, we were able to prove that tumblers averaged 3,700 servings--for the fantastically low cost of 1 4/5 cents per 1,000 servings.

Your Heat-Treated glassware stands up perfectly under rugged service conditions, and is a real money-saver in our restaurants.

Sincerely,

Charles F. Heywood

Charles F. Heywood
Purchasing Agent



Mr. Charles F. Heywood
Purchasing Agent
Hayes-Bickford Lunch System, Inc.
Boston, Massachusetts



Hayes-Bickford restaurants are familiar throughout Boston for fine meals moderately priced.

Mr. Charles F. Heywood, Purchasing Agent for Hayes-Bickford, operating 17 restaurants in Boston, Mass., has proved the operating economy provided by Libbey Heat-Treated DATED Glassware.

It's a simple matter to make your own survey. For eight years a code symbol indelibly marked on the bottom of every Heat-Treated glass has made it possible to trace the use of each glass. A check of this glassware will quickly show its amazing dura-

bility and resulting economy in restaurant operation.


Economical operation is further assured by the famous Libbey guarantee: "A new glass if the rim of a Libbey 'Safedge' glass ever chips."

Your Libbey Supply Dealer has full details on how Heat-Treated DATED Glassware can minimize your glassware costs.

See him or write to Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.



This symbol appears on the bottom of every Heat-Treated DATED glass. Left number indicates year of manufacture, right shows quarter. Add up the number of servings to prove the unbelievable economy of this glassware.

LIBBEY HEAT-TREATED GLASSWARE
AN  PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES • TOLEDO 1, OHIO

Onan
ELECTRIC PLANTS
**ELECTRIC PLANT
NEWS**



Power outages can do no harm in this hospital

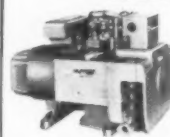
Onan Electric Plant supplies emergency power for lighting and all vital electrical equipment

An Onan Emergency Power System protects patients and personnel. Supplies current for lighting corridors, operating rooms, delivery rooms, stairways; provides power for heating system, ventilators, elevators, X-Ray machines, and other vital equipment.

Your hospital is assured of electric power at all times with Onan Emergency Electricity. Operation is completely automatic. When highline power is interrupted, the plant starts automatically; stops when power is restored.

Models for any size hospital—1,000 to 75,000 watts A.C.

Complete standby systems at lower cost



Onan Vacu-Flo cooling permits using air-cooled models in many installations at a considerable saving. Check Onan before you specify.

See your
architect or
engineer



Write for
Standby
Folder

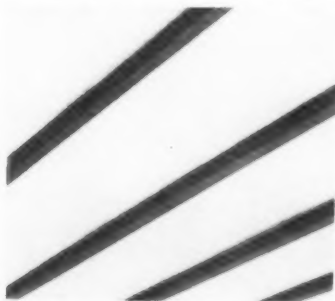
D.W. ONAN & SONS INC.

3559 University Avenue S.E.
Minneapolis 14, Minnesota

WHAT'S NEW

Combination Roof Deck Has Acoustical Finish

Noise-quieting properties are part of the under side of the new Armstrong

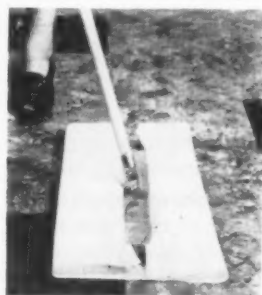


Cushiontone Roof Deck. The one product combines insulation, vapor barrier and interior finish acoustical material. It absorbs up to 60 per cent of the noise that strikes it and is made in two by eight-foot planks, two or three inches thick. The product is composed of layers of asphalt-impregnated insulation board, laminated to an interior surface of insulation board which has been perforated to muffle noise, and painted with a flame-resistant finish. Armstrong Cork Company, Lancaster, Pa.

For more details circle #396 on mailing card.

Disposable Treated Cloth for Floor Maintenance

A new disposable treated cloth and sweeping tool have been designed for efficient, dustless sweeping. The tool permits floor or wall areas to be cleaned without oiling, dampening or chemical sprays. The Masslinn cleaning cloth, a



combination of cotton and rayon fibers, is uniformly impregnated with a special emulsion which picks up dust and dirt without scattering and leaving deposits on floors or edges of rugs.

The cloth is used with a new sweeping tool constructed with an all-directional swivel joint which permits it to reach low spots, corners and between furniture at any angle. The large front surface cleans large areas with each sweep while the narrow side permits cleaning in restricted areas. Chicopee Mills, Inc., Non-Woven Fabrics Div., 47 Worth St., New York 13.

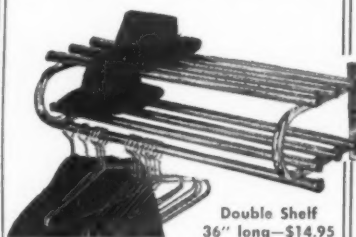
For more details circle #397 on mailing card.

(Continued on page 228)

A Sound Investment keep waiting chairs free

USE

COAT & HAT RACKS



Double Shelf
36" long—\$14.95

Sturdily made—1" Tubular Steel. Quality, mirror-like Chrome finish. Attach on standard 16" stud centers. Available in Single, Double, Triple shelves. In 2-3-4-5-6-foot lengths. Also Floor Models—with 1 1/2" square posts. Casters and umbrella racks optional. Sturdy Hangers with open or closed hooks.

Single Shelf	Double Shelf
124.....\$ 8.95	224.....\$13.45
136.....9.95	236.....14.95
148.....11.95	248.....17.95
160.....14.45	260.....23.95
172.....17.95	272.....29.95

Shipped KD with screws for easy assembly.

Precision Mfg. Co. 831 Chicago Ave.
Evanston, Ill.

HOW TO SELECT THE APPROPRIATE BRONZE PLAQUE

Consult International Bronze for dignified, permanent bronze plaques. Remember, there's no finer aid to fund raising...

FREE Illustrated brochure shows hundreds of original ideas for reasonably-priced, solid bronze plaques, nameplates, memorials, etc.

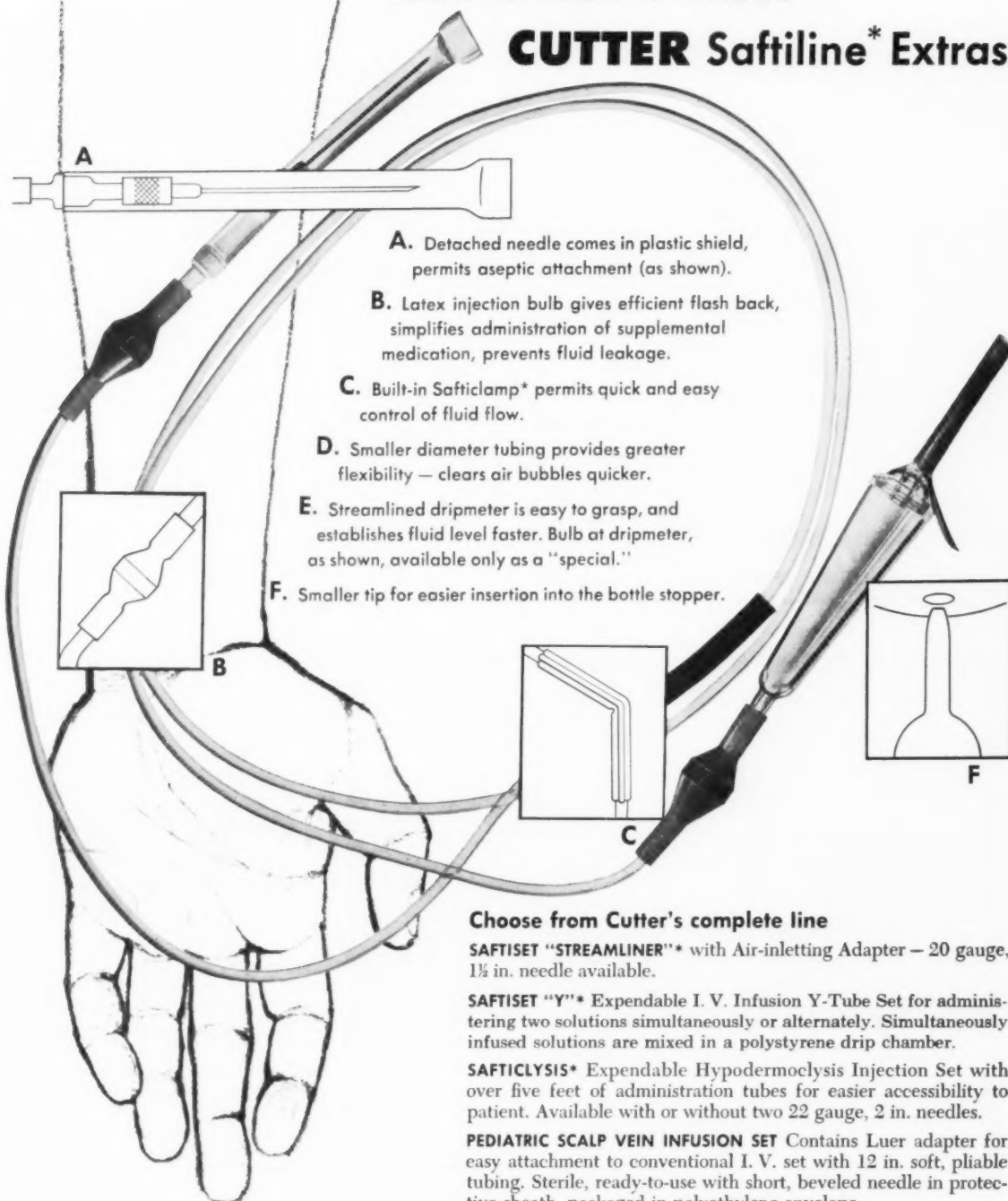
Write
today
to
Dept. 55

INTERNATIONAL BRONZE TABLET CO., INC.
150 West 22nd St., New York 11, N.Y.

Choosing I. V. Sets?

Take a look at these

CUTTER Saftiline* Extras!



- A. Detached needle comes in plastic shield, permits aseptic attachment (as shown).
- B. Latex injection bulb gives efficient flash back, simplifies administration of supplemental medication, prevents fluid leakage.
- C. Built-in Safticlamp* permits quick and easy control of fluid flow.
- D. Smaller diameter tubing provides greater flexibility — clears air bubbles quicker.
- E. Streamlined dripmeter is easy to grasp, and establishes fluid level faster. Bulb at dripmeter, as shown, available only as a "special."
- F. Smaller tip for easier insertion into the bottle stopper.

Choose from Cutter's complete line

SAFTISET "STREAMLINER"* with Air-inletting Adapter — 20 gauge, 1½ in. needle available.

SAFTISET "Y"* Expendable I. V. Infusion Y-Tube Set for administering two solutions simultaneously or alternately. Simultaneously infused solutions are mixed in a polystyrene drip chamber.

SAFTICLYSIS* Expendable Hypodermoclysis Injection Set with over five feet of administration tubes for easier accessibility to patient. Available with or without two 22 gauge, 2 in. needles.

PEDIATRIC SCALP VEIN INFUSION SET Contains Luer adapter for easy attachment to conventional I. V. set with 12 in. soft, pliable tubing. Sterile, ready-to-use with short, beveled needle in protective sheath, packaged in polyethylene envelope.

For Complete Information on Cutter's Saftiline Write Dept.

GOING TO THE A.H.A. CONVENTION?
DROP IN AND SEE US AT BOOTH 534.

*T.M.



fine pharmaceuticals for 60 years

CUTTER LABORATORIES
BERKELEY, CALIFORNIA

Rapid Electric Sterilization with DRY HEAT

Despatch

ELECTRIC STERILIZERS . . .



will provide thermostatically controlled temperatures to 400° . . . reinforced body with double-steel walls and doors . . . easy-loading adjustable shelves . . . 3-heat switch for fast or slow pre-heating . . . low operating cost.

Heat penetrates rapidly to destroy bacteria on instruments, glassware, needles. Positive sterilization is guaranteed. Designed to meet the usual requirements of hospitals, laboratories and medical depots. Easy to operate—just turn the switch and set at the desired heat. Six capacities, 110 or 220 V AC, available for quick delivery.

Ask Your Dealer or Write For BULLETIN NO. 110



DESPATCH

Established OVEN CO. in 1902

DESPATCH OVEN COMPANY
333 DESPATCH BLDG., MINNEAPOLIS 14, MINN.

FULFILLING THE STRICTEST DEMANDS ...FOR OVER A CENTURY!



The kitchen and cafeteria equipment of the recently erected Abraham Jacobi Hospital* was completely fabricated and installed by Straus-Duparquet.

Designed to conform with the standards of the National Sanitation Foundation, this all stainless steel equipment functions with the efficiency and economy afforded only by the most modern techniques of our day.

Another example of the unique facilities offered by the "complete service" of the world's largest suppliers of institutional and restaurant equipment and furnishings.

Our vast experience and facilities permit us to meet your most exacting standards. Contact our firm nearest you for further information.

*Abraham Jacobi Hospital, Bronx, N.Y., erected by the New York City Dep't of Public Works, Frederick H. Zornhagen, P.E., R.A., Commissioner; Pomerance & Breines, Architects.

STRAUS-DUPARQUET inc.
33 EAST 17th STREET NEW YORK

ALBERT PICK CO., Inc.
8198 WEST PERSHING ROAD CHICAGO, ILL.

WHAT'S NEW

Electriduct Extension Cord Carries Over Floor

An unobtrusive method of carrying electric extension cords over the floor to



electric typewriters and other office machines, diagnostic and other instruments is offered in Electriduct. The rubber duct protects the electrical wiring and is stumble-proof as it rises from a feather edge to an apex of 7/16 of an inch. Wheeled equipment can be easily rolled over it. Ribs on the under side prevent the Electriduct from slipping on the floor. Wiring is placed in the hollow duct center, or the duct can be made as a complete electric extension cord. Ideas, Inc., 615 South 2nd, Laramie, Wyoming. For more details circle #398 on mailing card.

Black Plastic Mulch Simplifies Grounds Maintenance

Kordimulch is the name given to a new inexpensive black plastic garden mulch for landscape and ground maintenance. Extensive tests conducted at agri-



cultural experiment stations in a variety of climates and soil types indicate that its use reduces maintenance costs. Plants grown using the mulch, which is porous but holds moisture in the soil, are described as bigger, earlier and healthier. Less watering is necessary when the plastic mulch is used and there are no weeds to pull.

To use, Kordimulch is unrolled over the spaded garden area, slit with a razor blade or knife over the spot to be planted, and either seeds, bulbs or partially-grown plants are planted through the slits in the soil below. The film can be unrolled over an existing garden, holes slit and growing plants pulled through the openings. Loose soil placed around the edges anchors the film. Kordite Company, Macedon, N.Y.

For more details circle #399 on mailing card.

(Continued on page 230)

NEW MOBILE "200"

*a General Electric x-ray unit
in step with your progress*



NOW! A full-range x-ray unit for bedside radiography

Here's the power of a fixed x-ray installation plus complete mobility. With the new General Electric Mobile "200" you get all these features:

- Full 200-ma, 100-kv output.
- Identical components, circuits and controls to those in major x-ray apparatus.
- Easy-rolling, rubber-tired movement that puts full x-ray power at any point in the hospital.
- Operation from wall outlets—Any adequate 230-volt

line will do. You can also work from 115 volts at reduced power.

With every feature essential to modern radiography, the Mobile "200" will prove a real asset in improving the quality of service and expediting case handling. Even within the x-ray department, it's an ideal standby unit when heavy loads swamp existing facilities.

Get full details from your G-E x-ray representative. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. H-91.

Progress Is Our Most Important Product

GENERAL  ELECTRIC

WHAT'S NEW

No Messy Fingers with Quick-Change Ribbon



The messy job of changing typewriter ribbons is eliminated with the new Royal "FP" Standard Typewriter by the use of the Twin Pak quick-change ribbon.

Twin plastic cartridges are held in either hand, the ribbon laid in place in the newly-designed ribbon carrier and each plastic cartridge dropped into place.

The white gloves worn in the illustration demonstrate the cleanliness of the operation as fingers touch only the plastic containers, never the inked ribbon. The new typewriter also offers a fast, smoother typing touch, 30 per cent increase in quietness and two-color styling in addition to other improvements. **Royal Typewriter Co., Div. of Royal McBee Corp.,** Westchester Ave., Port Chester, N.Y.
For more details circle #400 on mailing card.

Fiber Covers for Disposal Cans



Fiber covers have been designed for use with the Federal Fibre's line of heavy duty Fiberok cans to reduce the noise in handling disposal cans. "Quiet Covers" are constructed of specially vulcanized and hardened fiber and fit snugly over all size cans from 12 to 24 inch diameters. The covers are fitted with special leather handles and are available in brown or green. **Federal Fibre Corp.,** 3704 10th St., Long Island City 4, N.Y.

For more details circle #401 on mailing card.



WHITE CROSS HOSPITAL

COLUMBUS, OHIO

patients and White Cross Hospital like Van Kitchen

- Both the patients and the administration of White Cross Hospital, Columbus, Ohio, are delighted with the results that stem from this gleaming stainless kitchen serving five floors of one wing.
- Now that equipment of the vintage of 25 years ago has been replaced with the most modern Van so well knows how to design, fabricate and install, trays arrive at the bedside with foods and beverages fresh or hot as the patients like them. A duplicate tray service unit will soon be installed in the other wing.
- When you need kitchen equipment, call Van and tap its unique century of experience.

The John Van Range Co.

EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD

Branches in Principal Cities

401-407 EGGLESTON AVE.

CINCINNATI 2, OHIO

Single Tank Dishwasher Has Removable Interior Parts

The new Universal SD Deluxe Model single tank dishwashing machine features interior parts which can be removed by



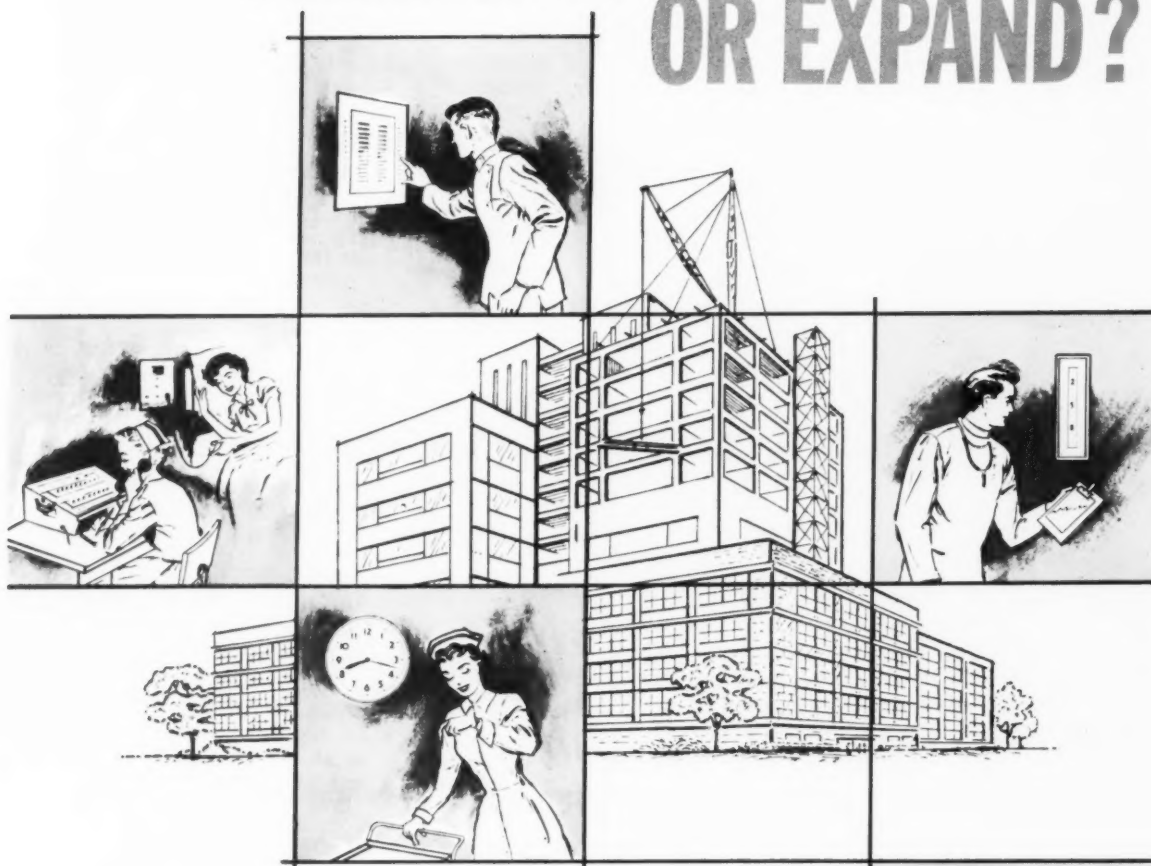
hand, including tracks, strainer pans, shelves and wash and rinse assembly, for complete and easy cleaning. The semi-automatic machine with three doors can be connected for straight-through or corner operation.

The all stainless steel unit handles 19 1/4 square inch racks and is designed with power wash and rinse revolving above and below the dishes. The wash and rinse, which cannot operate together, are activated by a single finger-tip lever which also operates the three-door interlock. Optional equipment includes automatic timing control for wash and rinse cycle and booster heater equipment. **Universal Dishwashing Co.,** Nutley 10, N.J.
For more details circle #402 on mailing card.

(Continued on page 232)

PLANNING TO

MODERNIZE OR EXPAND?



If you are, you can save time, trouble and money by seeing your local Edwards Technical Specialist now. He's an expert who knows all there is to know about hospital signaling. He'll be happy to show you how simple it is to expand or improve your existing signaling equipment to provide you with the most modern system at minimum cost.

The Edwards Technical Specialist can show you a complete line of in-and-out registers, call systems, paging systems, clock systems, fire alarms . . . all designed to combine perfectly with your present equipment to give you the most modern systems with the least possible expense. A prime example is the visual nurses call system. In most cases the existent system can be converted to the newest, most efficient audio-visual system simply and inexpensively.

When you select Edwards to help you solve your expansion signaling problems, you receive the benefits of more than 80 years of specialization in the design, development, and manufacture of fine signaling equipment.

For expert assistance in determining the signaling needs of your modernization or expansion program, consult your Edwards Technical Specialist (they are in 53 key Canadian and U. S. cities) or write Dept. MH-9, Edwards Company, Inc., Norwalk, Conn. (In Canada: Edwards of Canada, Ltd., Owen Sound, Ontario.)

specialists in signaling since 1872

EDWARDS

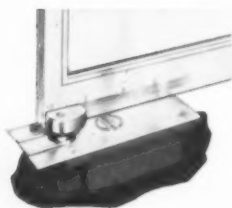
DESIGN • DEVELOPMENT • MANUFACTURE

Low Cost + Low Cost INSTALLATION MAINTENANCE



DOR-O-MATIC CONCEALED IN FLOOR MANUAL DOOR CONTROLS

Superior design of DOR-O-MATIC controls makes them simple and inexpensive to install. Rugged construction requires minimum maintenance. Positive two-speed closing action with any type door. No unsightly detracting from beauty and design because DOR-O-MATIC controls are concealed in the floor.



Positive built-in backstop—eliminates door or floor applied stop devices. Built-in hold-open. No seasonal adjustments necessary. Thirty-one models to choose from.

Write for detailed information.

**DOR-O-MATIC INVISIBLE
DOR-MAN**—For completely
automatic door controls
in carpet or handle
actuated models.



Sales and Service in Principal Cities



DOR-O-MATIC division of REPUBLIC INDUSTRIES, INC.
7348 West Wilson Avenue
Chicago 31, Illinois

CANADA: Dor-O-Matic of Canada, 550 Hopewell Avenue, Toronto 10, Ontario
EXPORT: Consultants International, 69-77 Bedford Street, Stamford, Connecticut

WHAT'S NEW

Franklin Tilt Bed Facilitates Therapy

Patients too weak or ill to be transferred to a tilt table for treatment can



be placed on the new Franklin Tilt Bed. When treatment is prescribed the bed, which provides for all standard hospital bed positions and adjustments, is used for therapy. It is designed to handle prescribed treatment in cardiac conditions and to aid in weight bearing and prevention of related complications caused by prolonged periods of lying prone.

The new bed is adjustable from 10-degree Trendelenburg through full 90-degree standing by means of a combination side-cranking, Gatch-type spring and a motorized tilting mechanism. The single-phase explosion-proof motor is actuated by a remote control switch which permits the operator to help the patient or to make adjustments in the foot of the bed. The Franklin Tilt Bed requires no extra floor space and moves through all degrees of the tilting position without any movement from its location. Franklin Hospital Equipment Co., 116 Academy St., Newark 2, N.J.

For more details circle #403 on mailing card.

Four-Speed Food Mixer Available in Two Sizes



The new Reco Food Mixer features four separate positive and distinct speeds in operation. The planetary arm action and beater both revolve in the same direction, ensuring complete, uniform mixing. The mixer is available in either 12 or 22-quart capacity and the modern streamlined design makes cleaning easy. Reynolds Electric Co., 3000 River Rd., River Grove, Ill.

For more details circle #404 on mailing card.

(Continued on page 234)

IRON FIREMAN *SelectTemp* HEATING



Temperature can be
accurately regulated
in each separate room



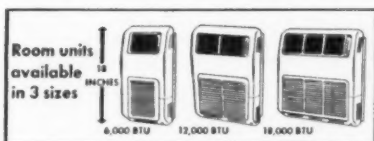
The revolutionary new heating system with a thermostat in every room

With SelectTemp, the new, yet proved method of modern heating, the temperature of *each* room can be regulated to fit the patient's needs, day and night. Each special room—nursery, surgery, recovery rooms—can be held at the temperature desired. The selected temperature is uniform throughout the room, with a gentle, steady circulation of clean, filtered air. Each room is its own heating zone with responsive thermostatic control, providing real comfort and proper individual care for each patient.

Safe in operating rooms and laboratories. Each steam operated room unit contains a filter, an air circulating fan and an individual

thermostat. Both fan and thermostat are non-electric. Since no electricity is used, SelectTemp units are spark-free and safe in rooms where inflammable gases are present.

Easy and economical to install. In new construction or modernization, the SelectTemp system can be quickly installed at a cost that is no greater than many systems which do not provide the many SelectTemp



advantages. Some hospitals have first replaced steam radiators with SelectTemp units in a limited number of rooms, and have later extended the system throughout the building. In addition, SelectTemp heating is being specified for new additions.

No overheating—low operating costs. When a window is opened to cool an overheated room, costly fuel is wasted. This waste is avoided with SelectTemp heating. Heat can be reduced in rooms temporarily not occupied. Such rooms can be quickly reheated when needed. Users report substantial savings in fuel bills.

For cooling. Individual unit cooling, with SelectTemp heating, makes the perfect all-year combination for patient and employee comfort, and for low cost operation.

Send for free literature on the SelectTemp heating system. Use coupon below.

IRON FIREMAN®
Engineered
HEATING & COOLING



IRON FIREMAN MANUFACTURING CO.
3413 West 106th Street, Cleveland 11, Ohio
(In Canada write to 80 Ward Street, Toronto)

- ☐ Please send more information on SelectTemp heating.
☐ Arrange for brief demonstration of SelectTemp room unit, in actual operation, in our office.

Name _____
Hospital _____
Address _____
City _____ Zone _____ State _____

*pays
its
way...
day by day!*



Cat. No. 8396

the new

STANLEY WINDSOR unbreakable beverage server

Serve it hot. Serve it cold. And never again worry about breakage costs! The new Stanley Windsor is gleaming stainless steel inside and out. It's built to last a lifetime. The Windsor comes with a new thumb-lift hinged lid, an oversize stay-cool handle and large non-drip pouring lip. Write us today for full information. You'll be amazed at the low, low price.

STANLEY INSULATING DIVISION Landers, Frary & Clark, New Britain, Conn.

LIGHTWEIGHT FOOT STOOL

ALL ALUMINUM

TIP-PROOF

RECESSED RUBBER TOP



High strength with light weight. Easy clean rubber top. Extra large top 10" x 16" x 8" high. Polished aluminum or anodized finish.

Beam Metal Specialties

Please request our new catalog

25-11 49th STREET
LONG ISLAND CITY 3, N. Y.

WHAT'S NEW

Side Arm Traction Attaches to Bed

The No. 908 Side Arm Traction Frame may be attached at any point

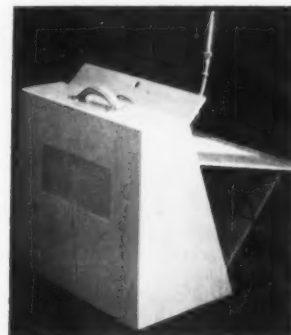


along the side of the bed frame, even on the sections that may be elevated. The traction remains unchanged when the back rest is raised or lowered, eliminating the necessity for keeping the patient in a stationary position while in traction. The same frame may be attached to the end of the bed for traction of the leg or foot. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #405 on mailing card.

Public Address System in Portable Form

The new Davis Folding Sound Lectern has its own built-in public address system. The full unit is about the size of a small suitcase and can be easily carried to place of use. The microphone and reading lamp are held in the top



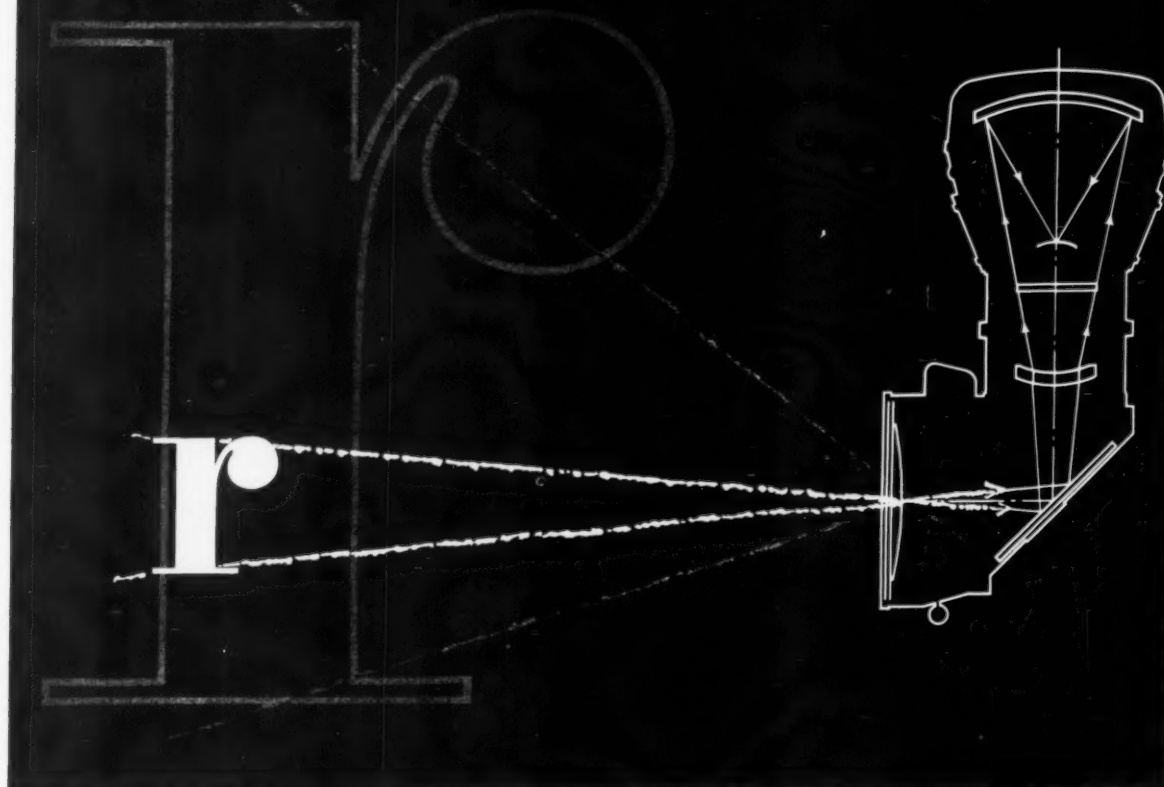
compartment when carried and the desk folds into the cabinet. When the amplifier is turned on, the speaker is ready to reach an audience of 50 to 500 people.

The cabinet is of rift white oak with hand rubbed lime oak finish. Provision is made for mixing two microphones and a phonograph or recorder. There are two built-in loudspeakers, and remote speakers may be added for large groups. The Davis Folding Sound Lectern is 19 inches high, 20 inches wide and 11 inches across the bottom when folded. **Davis Sound, 106 Main St., Madison, N.J.**

For more details circle #406 on mailing card.

(Continued on page 236)

REDUCED RADIATION . . .



Radiation exposure

reduced 70-80%

with concentric mirror photofluorography

The Fairchild-Odelca photofluorographic camera, with its Bouwers Concentric Mirror Optical System, offers a practical solution to the problem of radiation in X-ray examination. Because its speed is four times that available in present refractive lens cameras, patient exposure to X-ray is reduced by 70-80%.

Diagnostic quality negatives

At the same time, resolution is more than doubled—which insures sharp, crisp negatives of diagnostic quality. The resolution of this system exceeds that of the fluorescent screen. The camera's speed also stops much voluntary and involuntary motion, virtually eliminating retakes.

Economically speaking, the Fairchild-Odelca is exceptional, for the 4" x 4" size means low film cost and minimum storage space. Pre-focusing and pre-positioning make operation simplicity itself . . . and there are no heavy cassettes to handle. (Also available in 70 mm. roll-film models for mass chest survey, hospital admissions and serial radiography).

For details, contact your regular X-ray equipment dealer, or fill in the coupon below. Address Fairchild Camera and Instrument Corporation, Industrial Camera Division, 88-06 Van Wyck Expressway, Jamaica, New York, Dept. 160-50Pl.

FAIRCHILD
X-RAY CAMERAS AND ACCESSORIES

Please send me:

- ☐ Bulletin on the Fairchild-Odelca 4 x 4 Camera.
- ☐ Bulletin on the Fairchild-Odelca 70 mm. Cameras.
- ☐ Technical data on mirror-optics photofluorography.

Name

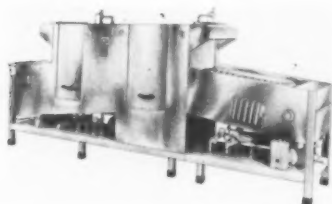
Title

Street

City Zone State

WHAT'S NEW

Single Tank Dish Washer in Upright Conveyor Type



The new Champion Model UC-116 dish washing machine is a single tank, upright conveyor model for use where

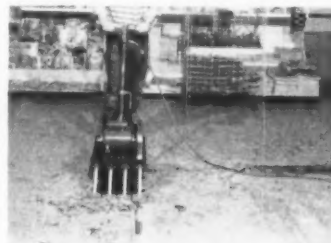
space is at a premium. The overall length of the machine is 11 feet six inches, yet it has a capacity range of 4500 to 6500 dishes per hour.

The patented conveyor belt is constructed of molded nylon links, reinforced with stainless steel cross rods, encased in plastic sleeves so that no metal can touch or mark the dishes. The lowered extension doors provide air circulation for rapid dish drying and the machine is equipped with self-draining pump integral with motor. **Champion Dish Washing Machine Co., 311 State St., Erie, Pa.**

For more details circle #407 on mailing card.

Automatic Tile Remover Strips Off Flooring

American Floor Machine announces a portable electric tile remover which automatically strips off old composition flooring. The Tile Remover not only removes tiles five times faster than hand methods,



but reduces the time floors are out of service. It has four 3½-inch wide steel cutter blades whose angles can be adjusted for the type of tile, thickness, bonding agent or other factors. The machine cleans a 14-inch path on every cut and has a built-in grinding attachment. The handle adjusts to operator height. **American Floor Machine Co., Toledo 3, Ohio.**

For more details circle #408 on mailing card.

For the best solution to every TOAST problem...

There's no substitute for
Savory



Fast, convenient and dependable toasting during busy meal times is the answer to a serious problem—in hospitals, schools and institutions.

Undersized or inadequate toasting equipment creates service delays and appetite appeal may be destroyed unless toast is served crisp, fresh and hot.

Savory automatic conveyor type toasters provide the greatest toast production possible—6 to 12 slices per minute—and perfect golden brown toast every time.

Ask your Kitchen Equipment Dealer to show you how Savory can speed up food service and provide greater economies, or write:

Savory

**EQUIPMENT,
INCORPORATED**
120 Pacific St., Newark, N. J.

Movable Partitions Offer Flexibility

Workwall is the name given to a new movable partition suitable for the business office, examining rooms and other areas in the hospital where flexibility of arrangement is an advantage. Office furnishings of various types can be attached to or removed from the partitions quickly and easily without leaving marks or scratches.

The available choice of standard, corner and three-way uprights made of

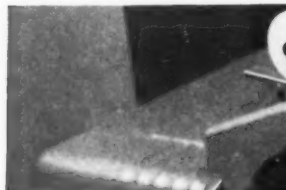


brass-finished anodized aluminum makes the Workwall completely flexible. The uprights are provided with grooves and rail locks for holding the sturdy Marlite plastic wall panels. Glass may be used as paneling where desired. A wire-way in the Workwall has a center strip separating electric from telephone wires, simplifying installations. The partition may be free-standing or attached to existing walls. **L. A. Darling Company, Bronson, Mich.**

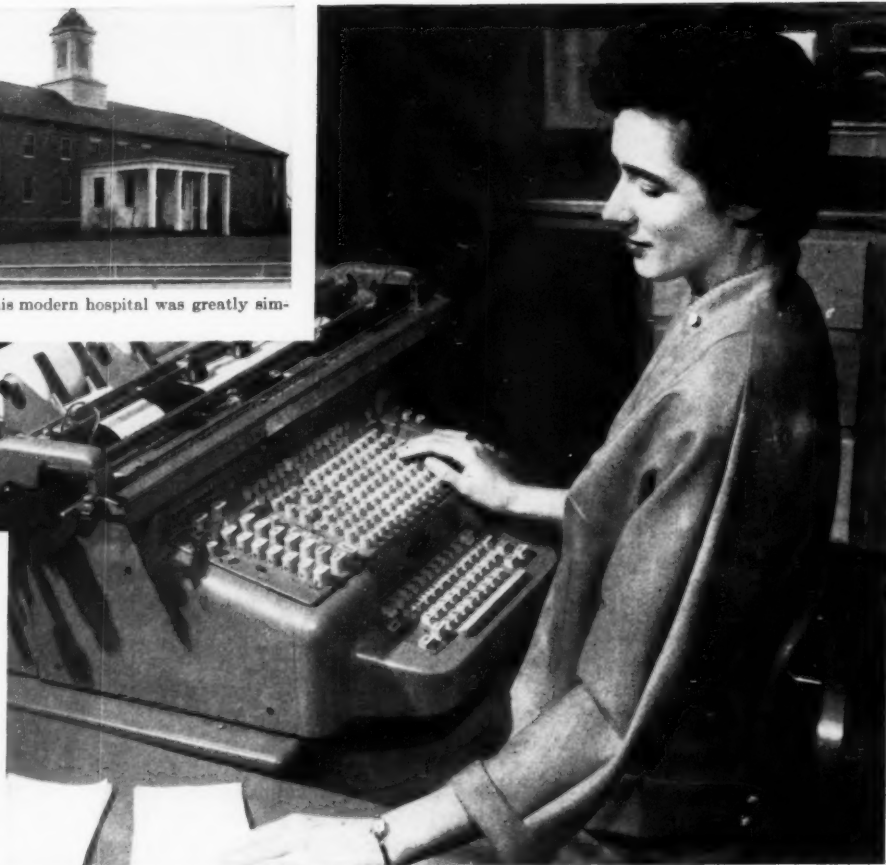
For more details circle #409 on mailing card.
(Continued on page 240)



THE ACCOUNTING PROCEDURE of this modern hospital was greatly simplified by a National System.



R. E. PIERATT, Administrator of the Central Michigan Community Hospital.



A NATIONAL ACCOUNTING MACHINE posts all records quickly and accurately.

**"Our *National* System
pays for itself every 2 years...
returns 50% annually on our equipment investment!"**

— Central Michigan Community Hospital, Mount Pleasant, Michigan

"Our bookkeeping department handled most of its work manually until we installed a National System," writes R. E. Pieratt, Administrator of the Central Michigan Community Hospital. "Our National has simplified our accounting, thereby making great savings in both time and money!"

"Our National 'Class 31' accounting machine reduces the time needed to complete the three most important phases of our accounting work: (1) patients' accounts receivable, (2) accounts payable and (3) payroll. It enables us to post records quickly and accurately. In fact, payroll alone is

now finished in half the time. And, because it is so simple to operate, our National '31' makes it easier for us to train new employees.

"We have been able to cut costs greatly because of the increased efficiency of our National System. It pays for itself every two years, returning 50% annually on our investment! We highly recommend the purchase of National accounting machines to any hospital."

R. E. Pieratt Administrator of the
Central Michigan Community Hospital

Your hospital, too, can profit from the time- and money-saving features of a National System. Nationals repay their original cost quickly, then return a regular yearly profit through savings they make for you. For complete information, call your nearby National representative. He's listed in the yellow pages of your phone book.

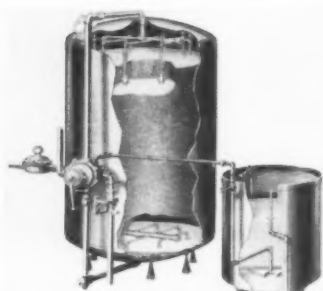
THE NATIONAL CASH REGISTER COMPANY, Dayton 9, Ohio
989 OFFICES IN 94 COUNTRIES





**SOME GOOD
ADVICE ABOUT
WATER SOFTENER
EQUIPMENT**

Now we take off our kid gloves!



ELGIN "DOUBLE-CHECK" WATER SOFTENER

—greatest value ever

- Up to 44% more soft water from a softener of given size.
- Prevents costly zeolite loss.
- Automatic or manual.

SOFT WATER saves money and increases efficiency throughout the hospital.

DEALKALIZERS prevent corrosion of steam condensate return lines and equipment.

DEIONIZERS produce mineral-free water to replace distillation at fraction of cost.

DEAERATING HEATERS supply pre-heated boiler water free of objectionable CO₂ and oxygen.



The man with the scowl (he might have been in charge of *your* plant) barked at an Elgin representative:

"Why didn't you tell me I was throwing my money away when I fell for that cheap water softener?"

Our rep thought he had properly covered that delicate subject the day Elgin lost out to a lower bid . . . but now we know the warning must have been couched in too polite language. This being the case, we are now taking off our kid gloves and speaking out in no uncertain terms.

We speak, not just for Elgin, but for all reputable and established manufacturers in the water softening field, when we say: Fight shy of the Johnny-come-lately in the water softener business—the upstart who says in effect: "A water softener is just a collection of tanks and pipes and valves; anybody can make it; I can give you the same thing at a lower price."

The SAME thing? Your first shock will come the day the cheap softener is delivered when you discover the woeful lack of real quality construction. The next blow will be to find its performance is a bitter disappointment. The final blow will be to find as the months and years roll along that as the man with the scowl said: you have thrown your money away!

Harsh words? Yes, but true! Your own experience has shown you that in today's tough competition the SAME thing at a LOWER price just does not exist . . . and this is particularly true of water softeners. It takes the kind of experience Elgin has had to build the softener you see here. It takes the kind of knowledge Elgin has accumulated from a half-century of experience to correlate all the elements that contribute to efficiency and economy as you find them in Elgin conventional and "Double Check" Softeners.

For facts, write for literature . . . or, better still, let us put you in touch with your nearest Elgin representative.

ELGIN SOFTENER CORPORATION

144 North Grove Avenue • Elgin, Illinois

Representatives in Principal Cities • In Canada: G. F. Sterne & Sons, Brantford



HOW TO DESIGN FOR LOW COST... in light construction

LIGHTSTEEL structural sections are carefully designed for maximum economy strength-to-weight ratio. Waste and high cost of overdesigned framing are eliminated, yet LIGHTSTEEL carries all the benefits of conventional steel framing.

LIGHTSTEEL cuts construction costs because joists, studs, track and bridging are designed to fit together for ease of assembly and welding in the shop or on the job. Because of the light weight of the sections, complete wall units can be trucked to the job site where they can be erected in a few minutes. Additional savings are effected by precisely engineered openings in the sections which simplify through-frame installation of wiring and plumbing.

The LIGHTSTEEL nailing groove is an alternate feature which permits nailing of collateral materials to double studs and joists.

Want to know more about economical LIGHTSTEEL? Fill out the coupon below and mail it today.

PENN METAL COMPANY, INC.

General Sales Office: 40 Central Street, Boston 9, Mass.
Plant: Parkersburg, W. Va.

District Sales Offices: Boston, New York, Philadelphia, Pittsburgh, Chicago, Detroit, St. Louis, Dallas, Little Rock, Seattle, San Francisco, Los Angeles, Parkersburg



PM-04

What is LIGHTSTEEL?

Penmetal LIGHTSTEEL structural sections are fabricated from structural-grade, strip steel by cold forming and are designed specifically for strength, light weight and low cost. Now, for the first time, the light building field can adopt steel framework economically.

The components include a complete range of studs, joists and accessories for the steel framing of houses, schools, hospitals, light commercial and industrial structures and exterior curtain wall framing in multiple story buildings — all hitherto limited to less desirable materials.

PENN METAL COMPANY, INC.

40 Central Street, Boston 9, Mass.

Please send me, without cost or obligation, a copy of
☐ LIGHTSTEEL catalog, SS-14, ☐ LIGHTSTEEL technical manual, SS-8.

Name

Company

Address

City..... State.....

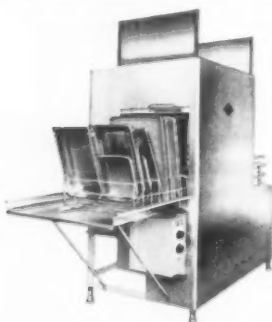
NEWEST A-F PAN and UTENSIL WASHER



Gives You All These Advantages

- Most efficient utilization of work space in majority of locations . . . reduces manual handling . . . eliminates overcrowding in wash area.
- Two vertical sliding doors counterweighted for easy operation . . . coupled to open simultaneously from both ends of the A-F Model "SD" Panhandler.
- Exclusive A-F oscillating Super Spray forcibly removes soil by direct high pressure contact from above and below.
- Sanitizes, with water hotter than human hands can stand. (Steam, gas or electrically heated.)
- Automatic wash-rinse cycle . . . timer adjustable from ½ to 5 minutes.
- Engineered for long-life, easy cleaning and maintenance.

Write for full information and price today.



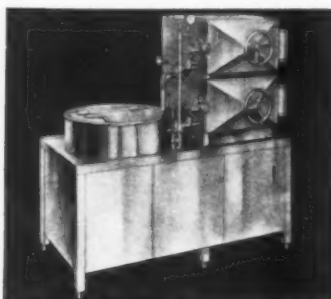
THE ALVEY-FERGUSON CO.

216 Disney Street, Cincinnati 9, Ohio
Representatives—Coast to Coast

WHAT'S NEW

Complete Menu Cooked in Combination Unit

A complete nutritious menu can be cooked with minimum kitchen heat, dis-



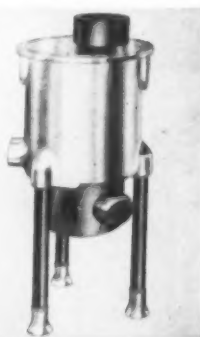
comfort and clean-up time in the new Market Forge Combination Unit. Designed originally for school cafeteria kitchen requirements, the unit will prove valuable in most institutional kitchens. It includes a steam cooker for vegetables, meats, poultry, sea food and frozen foods, and for pre-cooking or reheating, plus a steam kettle for soups, stews, gravies, casserole dishes, spaghetti and sauces.

The Combination Unit features low working height of kettle, swinging pantry faucet for ease in filling the kettle, one heavy duty trouble-free tubeless boiler, one set of easily installed connections and a built-in drain that collects condensate at one common point. Market Forge Co., Everett 49, Mass.

For more details circle #410 on mailing card.

Food Waste Disposers for Institutional Use

A new 1½ h.p. disposer has been added to the Herlex line of Food Waste



Disposers for institutional use. The new Model 4400 grinds all waste by specially designed continuous flow grinders which screen waste centrifugally around its 34-inch perimeter. Large particles are trapped between the grinders until completely ground, prohibiting clogging or slowing down. The unit is simple to maintain and easy to install as it is not necessary to bolt it to the floor. Herlex Mfg. Co., Willard Rd., Norwalk, Conn.

For more details circle #411 on mailing card.

(Continued on page 244)



Most Happy Patient

PICTURE: Good food . . . Hot food hot—Cold food cold served with no clutter and confusion . . . and served on time. RESULT: A Most Happy Patient . . . who will remember and tell his friends about the meals he enjoyed while hospitalized. Get the facts about Meals-on-Wheels System—you will be happily surprised to learn it cuts serving time in half, requires less serving help . . . actually saves you money.

Write for full details to:

Meals-on-Wheels System



Dept. N.O.
5001 E. 59th St.,
Kansas City 30,
Missouri

"See us at Booth 721 AHA Convention"

"DUXE" RESTRAINTS

FOR OPERATING TABLES, CHAIRS,
WHEELED STRETCHERS, BEDS.



NYLON
OR
COTTON

QUICK RELEASE
SAFETY-BELT
BUCKLES.

One- or two-piece.
Special lengths to order

INSTRUMENT LUBRICANT

"Sil-Spray"

SUCCESSOR TO OIL

Insist upon "Sil-Spray", the original silicone aerosol. Sil-Spray requires no germicidal additives to make it safe. It will not prevent autoclave sterilization. Rustproofs and prolongs life of valuable instruments.



ORDER FROM YOUR FAVORITE DEALER.
INSIST UPON THE ORIGINAL

DUXE PRODUCTS

205 KEITH BLDG. CINCINNATI, O.



The surgical team, moving through its highly skilled work, is the most dramatic of Hamot Hospital's service teams. Another team—made up of citizens of Erie, Pennsylvania—was mobilized under the direction of Ketchum, Inc. to send a \$3,000,000 campaign goal over the top. This was Ketchum's third successful hospital campaign in Erie.

HOSPITAL IMPROVEMENTS NEEDED... FUNDS RAISED

Ketchum, Inc. directs successful \$3,000,000 building campaign for Hamot Hospital, Erie, Pa.

The Hamot Hospital, Erie, Pa., needed funds for expansion. Added modern facilities were required to meet hospital needs for an increasing population. A goal of \$3,000,000 was set by the hospital's Board of Corporators . . . Ketchum, Inc. was engaged to direct the campaign.

A final report tally accounted for \$3,132,786 in subscriptions—\$132,786 over the goal. Satisfaction over the victory, and Ketchum's part in it was reflected in the statements of two community leaders—

- E. W. Nick, Steering Committee: "From our viewpoint, I doubt whether the goal could have been reached without the excellent efforts on (Ketchum Inc.'s) part . . . praise for your organization has been unanimous."
- Donald S. Leslie, president of the Hammermill Paper Company and Advance Gifts Chairman

for the campaign: "You may well be pleased and proud of the performance of the Ketchum, Inc. men who guided this campaign . . . a rare combination of strength, practicality and ability to keep moving ahead without upsetting people in the process."

If your Hospital is planning to raise funds, we will be happy to consult with your Board without obligation. Early planning will help to assure the success of your campaign.

KETCHUM, INC.

Campaign Direction

CHAMBER OF COMMERCE BUILDING
PITTSBURGH 19, PA.

500 FIFTH AVENUE, NEW YORK 36, N.Y.
JOHNSTON BUILDING, CHARLOTTE 2, N.C.



Exciting **NEW** Design!



Here is the perfect compliment to smartly modern interiors—a beautiful new "CHF" table to match the trend to trim, neat styling. Available in the warm, distinctive glow of Bronze or in 20 decorator colors of cast iron lifetime porcelain enamel.

ANYWHERE YOU LOOK "CHF" STOOLS AND TABLES ARE THE ULTIMATE IN QUALITY

CAST ONE-PIECE CONSTRUCTION

Classic unbroken line from floor to seat. Strongest, longest lasting construction available.

UNRIVALLED COLOR CHOICE

Only at "CHF" will you find 20 colors of porcelain enamel, plus 4 metal finishes.

AWARD WINNING DESIGNS

Every year "CHF" equipment is featured in the majority of NFS Contest Award Winners.



Write **TODAY** for complete catalog

See award winning installations, plus many ideas for finer interiors plus the complete "CHF" line

DISTRIBUTORS IN ALL PRINCIPAL CITIES

The CHICAGO HARDWARE FOUNDRY CO.

"Dependable Since 1897"

4197 Commonwealth Avenue

NORTH CHICAGO, ILL.

There's a FOSTER Refrigerator and Freezer for Every Hospital Need



Whether Your Bed Capacity Is 25 Beds or 500 Beds

Foster has had long and successful experience in building fine welded all-aluminum refrigerators and freezers for leading hospitals throughout the world. They have met every known in-the-field test for strength, durability, rugged service, low cost and long life.

Check List of Foster Hospital Refrigerator Needs

GENERAL SERVICE

Central Supply
Contagious Disease Wards
Maternity Wards
Nurses Stations
Pharmacy
Wards

LABORATORY

Bacteriology
Blood Bank
Clinical
Hematology
Pathological
Surgical

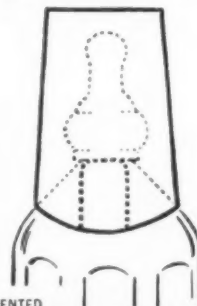
FOOD SERVICE

Bakery Department
Central Kitchen
General Cafeteria
Nurses Home
Snack Bar
Staff Restaurant
Ward Diet Kitchen



Foster Refrigerator Corp. Hudson, N. Y.

Remember...



*PATENTED

NipGard

TRADE MARK

DISPOSABLE NIPPLE COVERS...

provide space for identification and formula data... instantly applied to nipple; save nurses time... cover both nipple and bottleneck. Do not jar off. No breakage. Use No. 2 NipGard for narrow neck bottle... use No. H-50 NipGard for wide mouth (Hygeia type) bottle. Be sure to specify type desired.

for quick, dependable protection to nursing bottles... use the original NipGard covers. Exclusive patented tab construction fastens cover securely to bottle • For High Pressure (autoclaving)... for Low Pressure (flowing steam).



THE QUICAP COMPANY, Inc.

110 N. Markley St. (Dept. MH)
Greenville, South Carolina

Your hospital supply dealer has NipGards. Professional samples on request.



DE WITT and SWANK
Architects
J. A. JONES CONSTRUCTION CO.
Contractor

THE INVITING LOOK . . .

WITH *low-cost* VAMPCO ALUMINUM WINDOWS

The beautiful New Mound Park Hospital in St. Petersburg, Florida is an excellent example of why the architects chose VAMPCO All Aluminum Intermediate Combination Casement windows to accentuate the graceful, inviting lines of the building itself and, at the same time, provide the full natural lighting, good ventilation and lifelong natural beauty that is so essential in creating a cheerful atmosphere for its occupants.

For comfort and convenience . . . durability and beauty . . . low installation and upkeep costs, architects and contractors everywhere are turning to VAMPCO. Over 6,000 hospitals and schools in the United States alone now have VAMPCO Aluminum Window construction of one type or another. Find out how VAMPCO'S special designing service can help you solve your unusual building problems most economically and efficiently . . . mail coupon below today!

VALLEY METAL PRODUCTS CO.

PLAINWELL, MICHIGAN

SUBSIDIARY OF

MUELLER BRASS CO.,

PORT HURON, MICHIGAN



VAMPCO

See Complete File in Your
Current Sweet's Catalog

A NAME THAT MEANS THE
VERY-FINEST IN LIFELONG ALUMINUM WINDOWS

VALLEY METAL PRODUCTS COMPANY

DEPT. MH-97 PLAINWELL, MICH.

- ☐ Send 48-page Industrial-Institutional Window Catalog.
☐ Send Light Construction Aluminum Window Catalog.

NAME.....

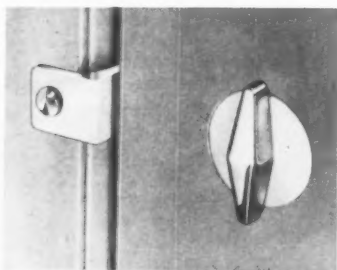
COMPANY.....

ADDRESS.....

CITY.....ZONE.....STATE.....

WHAT'S NEW

Concealed Latch for Toilet Partitions



Type 8800 Concealed Door Latch is a modern latch for toilet partitions with mechanism completely concealed within the door. The only exposed part is an attractive escutcheon plate and operating handle. The new latch is tamperproof, requires no maintenance or lubrication, and is quickly installed.

The cam-action principle gives easy, silent operation without the use of springs. The bolt is stainless steel, exposed parts are non-ferrous castings heavily chrome-plated and the recessed face and handle escutcheons facilitate cleaning. Sanymetal Products Co., Inc., 1676 Urbana Rd., Cleveland 12, Ohio. For more details circle #412 on mailing card.

Hot Food Storage Unit Is Easily Installed

The new Model HF5 Hot Food Storage Receptacle introduced by Hotpoint is constructed of a one-piece anodized aluminum chassis with a remote-control thermostat. The design permits fabricator-installation in any standard food table from top or bottom by several



optional methods. The anodized aluminum surface prevents water damage, even after prolonged moist operation. There are no welds or rough surfaces to trap dirt and the process permits superior heat transfer to the food containers. The new HF5 preheats in 10 to 12 minutes because of the stepped-up power. Stainless steel food containers may be used with the HF5 but anodized aluminum pots and pans give optimum efficiency, according to the manufacturer. Hotpoint Co., Commercial Equipment Dept., 6201 W. Roosevelt Rd., Berwyn, Ill. For more details circle #413 on mailing card.

Refuse Cans and Pails in Stainless Steel

The new Witt stainless steel cans and pails meet the health and sanitation re-



quirements of institutional use and are constructed of 24-gauge type 304 stainless steel with a 2B finish for heavy duty use. They are equipped with 1/4 by 2 1/4 inch stainless steel bands at top and bottom for added strength and longer wear. The lids fit snugly over the cans, yet are readily removed. Cans are available in 12 1/4, 16, 20, 27 and 33-gallon sizes and pails come in 5, 7, 8 1/4 and 10-gallon capacities. The Witt Corncore Co., 2121 Winchell Ave., Cincinnati 14, Ohio. For more details circle #414 on mailing card.

(Continued on page 246)

1907 ▾ 50 Years of Service to Physicians, Hospitals and Allied Institutions ▾ 1957

DISEASE INDEX		CODE NO.		TITLE		1954	
		36.-		Diseases and conditions of the lungs			
Orig. No.	Age	Sex	Result	DX	Etiology	Procedure	Physician
375612	11	M	I	360-	-153		J.T. Blank
371391	22	F	I	361-	-101		J.T. Blank
371211	27	M	I	360-	-202		J.W. Jones

**INDEXING FORMS FOR
DISEASES • OPERATIONS • PHYSICIANS**
*Vital for all medical research... and
essential for hospital accreditation*

Consider these Important Features of our Disease, Operation, and Physicians' Index Cards

- Conform to the latest edition of the Standard Nomenclature
- Designed by a leading authority in the medical record field
- Available for grouping by etiology and procedure
- Rulings spaced horizontally and vertically for typewriter use
- Can be conveniently used in either vertical or visible files
- Entire space utilized to provide for more entries per form
- Economically priced — available from stock
- Available in single or double (folded) card style

For Samples Write Dept. MH-957

Physicians' Record Company

161 W. Harrison Street ▾ Chicago 5, Illinois

MADE STRONGER WITH

JM ASBESTOS FIBRE



**For
longer wear
and less
maintenance
care**

A wide choice of colors, in J-M Terraflex tile, makes possible a number of decorative patterns and colorful flooring designs.

Johns-Manville ***Terraflex***[®] Tile gives best value for hospital flooring dollars

MADE OF VINYL PLASTIC, reinforced and strengthened with indestructible asbestos fibres, Terraflex tile will outwear most other types of decorative floor coverings two to one.

Available in a wide range of decorator colors, Terraflex will add beauty to flooring in corridors, lobby, wards, private rooms, cafeteria, labs, and classrooms.

Actual on-the-job figures show Johns-Manville's Terraflex tile slashes floor maintenance expense as much as 50 per cent, when compared with the next best resilient-type flooring.

It has a smooth, nonporous surface that defies the effects of grease, oil, strong soaps, and mild acids. Sweeping and an occasional soap-and-water mopping is virtually the

only attention this remarkable flooring requires throughout its long, trouble-free life.

Terraflex tile is not affected by alkaline moisture. It can be laid directly on concrete floors on grade, or below grade.

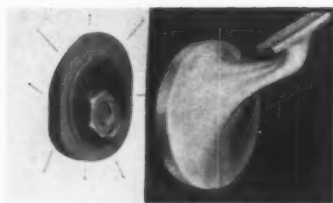
For more specific information on Terraflex Vinyl Asbestos Tile, write to: Johns-Manville, Box 158, New York 16, New York.



Johns-Manville

WHAT'S NEW

Hand Rail Brackets Are Instantly Aligned



Installation problems resulting from off-center anchor bolts are eliminated by the

new adjustable Ariston hand rail brackets which may be instantly aligned in any direction on the wall surface. The shell-molded bracket fits over the mounting plate and adjustment disc eliminating exposed anchor bolts and screws. The Ariston rail brackets are easily installed on plaster, concrete or wood and take any metal or wood handrail. They are finished in natural or alumilited aluminum and satin or polished bronze. Michel & Pfeffer Iron Works, Inc., Architectural Metals Div., 212 Shaw Rd., South San Francisco, Calif.

For more details circle #415 on mailing card.

Patient Sit-A-Bath Facilitates Bathing

A running water bath can now be provided for patients unable to bathe in a tub. The Sit-A-Bath is a lightweight unit made of Styrene which can be placed over the toilet bowl to give the



patient a complete shower bath without spillage. The hose is attached to a nearby faucet after the patient is seated in the Sit-A-Bath.

The unit is made in two parts, the upper portion acting as a supporting chair and the lower part placed on the ridge of the upper. No piping or plumbing is necessary for using the Sit-A-Bath which is ideal for use in hospitals, nursing homes and wherever patients can sit up for bathing. National Sales Co., 107 Johnson St., Saginaw, Mich.

For more details circle #416 on mailing card.

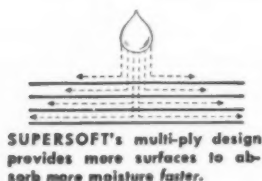


How Supersoft Napkins can reduce bed linen costs

Eating in bed is tricky business even for a steady hand. The obvious hazard is spilling which can mean soiled bed linens and the time lost in making changes.

For a measure of protection that flimsy paper napkins could never offer, serve with quick-absorbing Supersoft multiple-ply Napkins. Of finest facial tissue, Supersoft Cellosstrength Napkins are treated to retain strength even when wet.

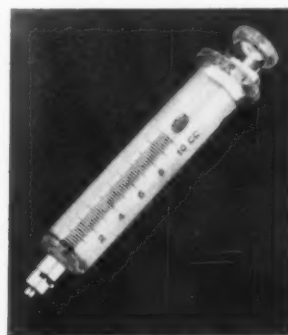
Too, their softness, their whiteness and their quality are so distinctive as to invite comments of pleasure from your patients. Many hospitals have already discovered how inexpensive it is to provide protection and gain good public relations with Supersoft Napkins. Quantity orders can be custom embossed or printed with hospital name, address, insignia, etc. Write today for your nearest supplier's name.



GROFF PAPER COMPANY • 2300 Endicott Street • St. Paul 14, Minnesota

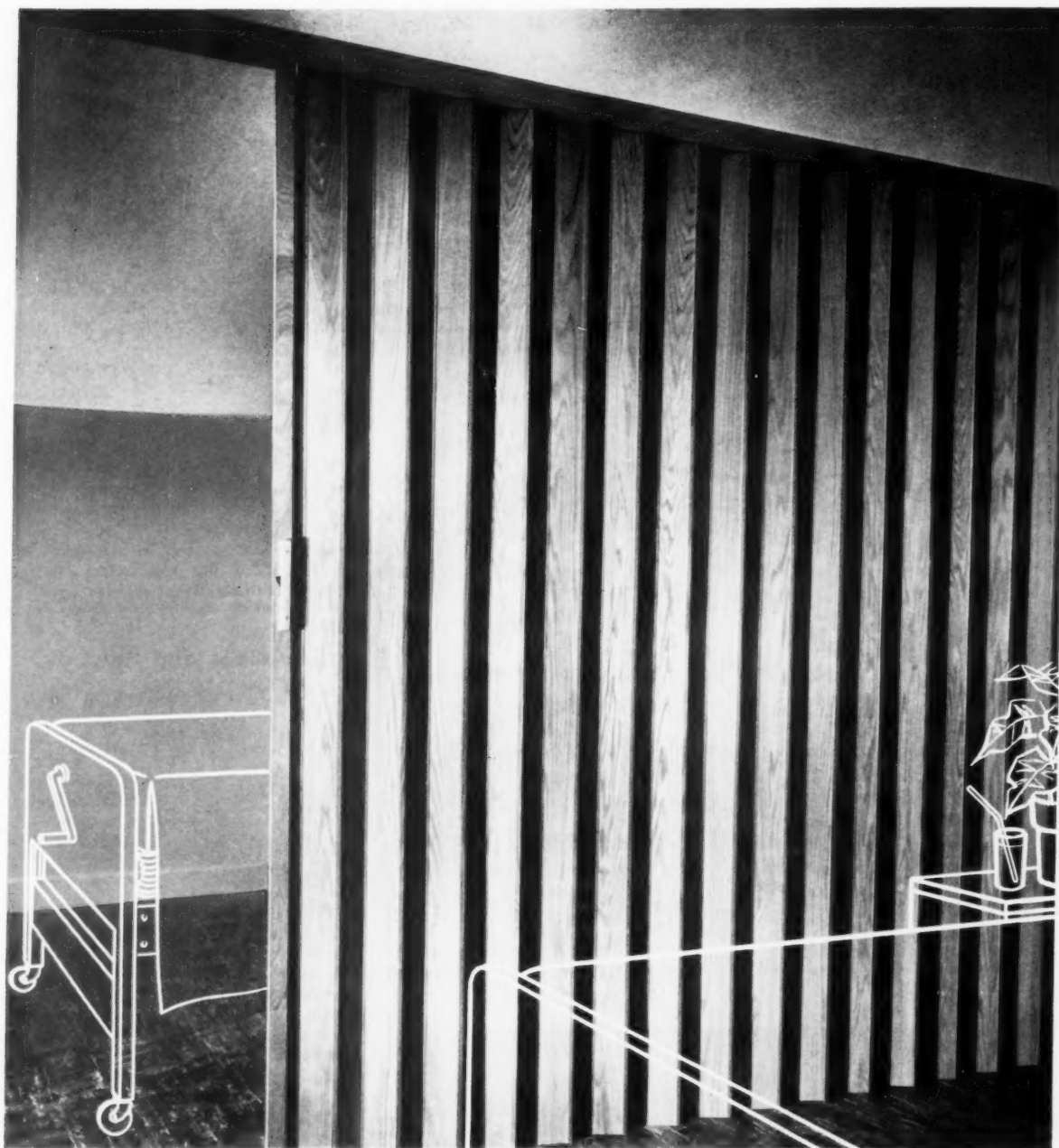
Heat-Resistant Glass for Hypodermic Syringes

Jena borasilicate heat-resistant glass is used in the new Kern hypodermic sy-



ringes. Longer life under repeated sterilization is claimed for the syringes which are also highly resistant to acids and alkali. The glass is treated in West Germany under an exclusive process and is now available in this country. The new syringes are individually tested for exact measurement and are offered in eight sizes, from one to 50 cc. Kern Laboratory Supply Co., 6839 Venice Blvd., Los Angeles 34, Calif.

For more details circle #417 on mailing card.
(Continued on page 248)



Privacy...when they want it



This attractive wood "folding wall" gives patients the privacy they want—and need. Sound-retardant, quiet closing, too—these PELLA DOORS are also ideal for post operation and post delivery recovery rooms. Sanitary, too. No inside mechanism and folds of material to harbor dust and other foreign material. Still other uses include: nursing and intern class rooms, inside recreation areas, hospital meeting halls. Doors are available in natural wood veneers, or if desired doors can be painted to match your color scheme.

WOOD FOLDING DOORS

ROLSCREEN COMPANY

Dept. I-104, Pella, Iowa

Please send FREE 6-page folder on
PELLA WOOD FOLDING DOORS.

NAME TITLE
HOSPITAL
ADDRESS
CITY ZONE STATE

WHAT'S NEW

Pharmaceuticals

Imferon

Imferon is a well-tolerated solution of iron-dextran complex providing the equivalent of 50 mg of elemental iron in each cc. It is easy to administer, quickly absorbed, promptly regenerates hemoglobin and rebuilds iron stores and is notably free from unpleasant or toxic effects. It is indicated for treatment of iron deficiency anemia when rapid hemoglobin response and replenishment of iron stores are important. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #418 on mailing card.

25 mg. Compazine Tablets

Compazine Tablets for rapid and effective tranquilizing of activity in patients with severe mental and emotional disturbances are now available in 25 mg. size. The higher strength unit is made available to facilitate high dosage regimens for severe cases. **Smith, Kline & French Laboratories, Philadelphia 1, Pa.**

For more details circle #419 on mailing card.

Milprem

Milprem is a new drug combining the tranquilizer Miltown with estrogenic hormones for treatment of symptoms associated with the menopause. It was

developed to provide relief from both the psychological and physiological symptoms. **Wallace Laboratories, New Brunswick, N.J.**

For more details circle #420 on mailing card.

Flexilon

Flexilon is a new combination skeletal muscle relaxant and analgesic. Each Flexilon tablet contains 125 mg. of Flexin and 300 mg. of Tylenol. The tablets are enteric coated to minimize the possibility of gastric upset. Flexilon is indicated for the treatment of orthopedic and rheumatic disorders. **McNeil Laboratories, Inc., 2900 N. 17th St., Philadelphia 32, Pa.**

For more details circle #421 on mailing card.

Sintrom

Sintrom is a new oral anticoagulant therapy for use in thromboembolic disorders, including coronary thrombosis, thrombophlebitis, arterial thrombotic occlusion, pulmonary embolism, selected cases of congestive heart failure and cardiovascular surgery. It is supplied in bottles of 50 double scored 4 mg. tablets. **Geigy Pharmaceuticals, Ardsley, N.Y.**

For more details circle #422 on mailing card.

Literature and Services

• "Bolta Floor Vinyl Flooring" is the subject of a colorful eight-page brochure offered by the Flooring Division, The General Tire & Rubber Co., Akron 9, Ohio. A two-page spread shows full-color reproductions of the floor and color illustrations picture actual installations. Descriptive information and specifications are included.

For more details circle #423 on mailing card.

• "How to Maintain Conductive Floors" is the title of a folder giving detailed information on the subject. The dangers of using a conductive floor that is not properly maintained are pointed out and instructions given for cleaning, protecting and testing this type of flooring. Safe levels of electrical conductivity as established by the National Fire Protection Association are also listed in the folder offered by Huntington Laboratories, Inc., Huntington, Ind.

For more details circle #424 on mailing card.

• Modular ceiling lighting systems and pendant lighting units are described in a new **Condensed Catalog** available from The Wakefield Company, Vermilion, Ohio. Illustrations of typical installations accompany the technical data.

For more details circle #425 on mailing card.

• Niagara Air Conditioners for institutional application are the subject of **Bulletin No. 133** issued by Niagara Blower Co., 405 Lexington Ave., New York 17. The coil surface type units are offered in capacities from 41,500 to 1,680,000 BTU per hour.

For more details circle #426 on mailing card.

(Continued on page 250)

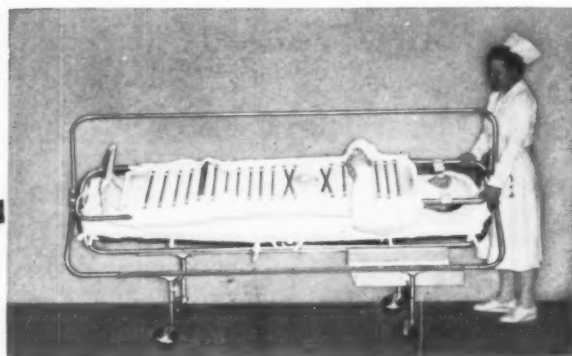
Did You Know That . . .

all **Stryker** TURNING FRAMES

- ... Can now be operated by one nurse with no need for extra help in turning ?
- ... have an enduring chrome plated finish ?
- ... Come complete with foam rubber or cotton mattress and sheets ?
- ... are completely assembled upon delivery with clear and concise operating instructions, with periodic servicing and maintenance available through your local dealer ?

The Stryker Turning Frames are the least expensive on the market. Make sure your new frame is a Stryker with all these features.

Write for free Turning Frame Manual and our new catalog.



Orthopedic

ORTHOPEDIC FRAME CO.

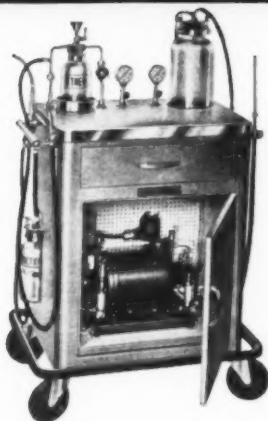
Kalamazoo

Michigan

Distributed in Canada by: Fisher & Burpee, Ltd., Winnipeg
Exclusive Agent for Export: Schueler & Co., 75 Cliff St., N. Y.

IMPROVED

... SKLAR-BUILT SUCTION AND PRESSURE UNITS

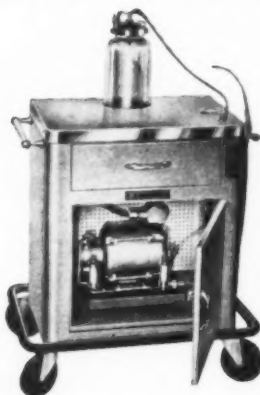


*Improved motor assembly and simplified electrical installation result in lower manufacturing costs which are reflected favorably in the prices of these new models.

These suction and anesthesia units are totally explosion proof and approved by Underwriters' Laboratories, Inc. for use in Class 1, Group C hazardous locations. All tubing, casters and bumpers on the Bellevue and Printz models are of conductive rubber. Motor units are rubber mounted, minimizing vibration. Cabinets are insulated with Celotex to insure noiseless operation.

NEW IMPROVED BELLEVUE MODEL, CAT. No. 100-75.

Now equipped with 32-ounce suction bottle for the exclusive use of the anesthetist in addition to the regular 1-gallon suction bottle and 32-ounce ether bottle.



NEW IMPROVED PRINTZ MODEL SUCTION UNIT, CAT. No. 100-80.

Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz Model, Cat. No. 100-85 (not illustrated)* has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

Printz Model, Cat. No. 100-87 (not illustrated) is same as 100-85 but equipped with separate rotary compressors for ether bottle and suction bottle.



NEW IMPROVED TOMPKINS MODEL SUCTION AND ANESTHESIA UNIT, CAT. No. 100-10.

Complete with 32-ounce suction bottle, 16-ounce ether bottle, two-way by-pass valve and spray tube. Sklar Pump Table, Cat. No. 100-40 (not illustrated) mounted on conductive rubber casters, complete with utility drawer, shelf and rack for sprays and sinus cleanser. *Tompkins Model for suction only, Cat. No. 100-15 (not illustrated)* is equipped with two 32-ounce suction bottles and no ether bottle.

Standard color for all units is Sklar silver grey baked enamel.

DESCRIPTIVE LITERATURE ON REQUEST



Sklar

LONG ISLAND CITY, N. Y.

Sklar Equipment is available through accredited surgical supply distributors.

FOR FASTER FLOOR MOPPING *and* REDUCED COSTS...



"FLOOR-PRINCE"
Mopping Outfit
for mops up to 24 oz.

... specify *Geerpres* the really
Efficient Mop Wringer!

See them in action and you'll realize why maintenance men *prefer* a Geerpres to ordinary mop wringers.

They make a tough job easier because of powerful, controlled squeezing action which wrings mops dry in a single operation. Patented design eliminates splashing once-cleaned floors. Moving is effortless because of ball-bearing, rubber casters.

Not only do you save costly labor time, but premium quality materials and construction—such as exclusive corrosion-resistant electroplated finish—assure long service life. Mops last longer, too, without twisting or tearing.

Write now for catalog listing all sizes and types, accessories, and hints for more efficient mopping.

GEERPRES WRINGER, INC.
P. O. BOX 658 MUSKEGON, MICHIGAN

POWERFUL NEW PLUNGER CLEARS CLOGGED TOILETS IN A JIFFY!



Clear messy, stuffed toilets
Cut maintenance costs with

'TOILAFLEX'
Toilet **ALL-ANGLE** Plunger

Ordinary plungers don't seat properly. They permit compressed air and water to splash back. Thus you not only have a mess, but you lose the very pressure you need to clear the obstruction.

With "TOILAFLEX", expressly designed for toilets, no air or water can escape. The full pressure plows through the clogging mass and swishes it down.

- Accordion-action design to flex at any angle
- Double-size cup blasts double pressure, aimed directly at obstruction
- Tapered suction-grooved tail gives air-tight fit

Order a "TOILAFLEX" for your own home too.
Positive insurance against stuffed toilet.

\$265 Fully
Guaranteed

Order from your Supplier of
Hardware or Janitor Supplies

THE STEVENS-BURT CO., NEW BRUNSWICK, N. J.
A Division of The Water Master Company

WHAT'S NEW

- How to save time, space and money with Spacefinder files is discussed in a new 24-page brochure available from Tab Products Co., 995 Market St., San Francisco 3, Calif. The advantage offered in the completely closed cabinet of the Spacefinder units and the x-ray filing unit are discussed and installations are pictured. Diagrams and drawings demonstrate specific savings of floor space. For more details circle #427 on mailing card.

- Two new color catalogs have been prepared by Azrock Products Div., Uvalde Rock Asphalt Co., Frost Bank Bldg., San Antonio, Texas. The first covers the latest **Azrock Asphalt Tile Line** while the second describes the current line of **Azphlex Vinylized Tile**. Both contain full color charts, typical installations and complete product information. For more details circle #428 on mailing card.

- The line of **Soap Dispensers** manufactured by Bobrick Dispensers, Inc., 1214 Nostrand Ave., Brooklyn 25, N. Y. is described in the 1957 Catalog issued by that company. Details and illustrations on liquid, powdered and lather dispensers, liquid and lather soap valves, tank-type soap systems and hand lotion dispensers are included. For more details circle #429 on mailing card.

- How aluminum foil saves time and money in institutional cooking is described in a new booklet, "Helpful Hints," prepared by Kaiser Aluminum Corp., Institutional Service Dept., 1924 Broadway, Oakland 12, Calif. Quantity recipes on detachable perforated card stock are included. For more details circle #430 on mailing card.

- "Dial Springtime Anytime" is the title of a new series of product folders describing air conditioners for commercial application, manufactured by Airtemp Div., Chrysler Corp., Dept. 620, 1600 Webster St., Dayton 1, Ohio. Form No. LL-241 describes water-cooled packaged air conditioners and Form No. LL-243, waterless air conditioning units. For more details circle #431 on mailing card.

- The features of the new "Koch Series 'M' Reach-In Refrigerators" are demonstrated in a new 18-minute sound film available from Koch Refrigerators, Inc., 401 Funston Rd., Kansas City 15, Kan. The film is available to any institution interested in an integrated system of cold-food handling for mass feeding. For more details circle #432 on mailing card.

- Kidde-Atmo Automatic Fire Detection Systems are described in a booklet available from Walter Kidde & Co., Inc., Belleville, N. J. The brochure points out why this system is needed and then explains in simple terms how the Kidde-Atmo operates. Various applications of its use in various situations are described and illustrated. For more details circle #433 on mailing card.

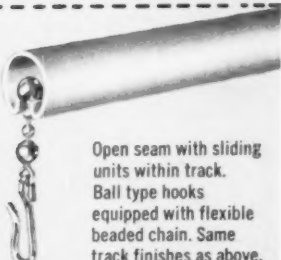
(Continued on page 252)

from the production lines
of the nation's
leading manufacturer
of sliding hardware
comes

3 complete lines of hospital
cubicle curtain hardware,
designed to meet every
operating condition and
engineered for fast, quiet
and dependable performance.



Seamless 1" O. D.
tubing for suspended
installations. In brass,
chrome plated
or aluminum with
anodized finish.



Open seam with sliding
units within track.
Ball type hooks
equipped with flexible
beaded chain. Same
track finishes as above.



Extruded aluminum
track with all nylon
rolling units
for ceiling installations.
Most advanced cubicle
design ever offered.

* A complete engineering department
is at your service, prepared to assist you
in the proper determination of hardware
as well as in the adaption of hardware
to existing hospitals or to new construction.

See the nation's newest line of Cubicle
Hardware at booth no. 251 at the A.H.A. Convention.
Sept. 30-Oct. 3, Atlantic City, N. J.

Write for new catalog
giving full descriptive
information.



Hospital Equipment Division
PULLEY & HARDWARE CORPORATION
69 High Street West Nyack, New York

what's **NEW** in maintenance by HILD

New Life-Wayte Vacuum Weights Only 19 Lbs.

New all aluminum vacuum cleaner for wet
and dry work—weight only 19 pounds. Light
enough for women to carry, yet gives same
dependable performance as large industrial
models. Market basket type handle and ball
bearing cushion casters make it easy to
move or carry—for use with 1½" or 1¼"
hose and tools. Free demonstration, say
where.



Model 404

New 24" Floor Machine

New 24" Hild Floor Machine handles easier
than most small models—ideal for schools, hos-
pitals, churches and institutions with large floor
areas to maintain. Adjustable handle, safety
switch and non-marking bumpers—interchange-
able attachments for scrubbing, waxing, polish-
ing and buffing. Shower-feed tank on handle
available for fast scrubbing. Has the "right
weight and feel" for easy thorough cleaning.
Free demonstration offered.



Model E

Vacuum Cleaner with 3" Intake

New 15 gallon vacuum with special intake
for 1½", 2" and 3" hose. Allows operator
to switch from 1½" hose for light general
vacuuming to 2 or 3 inch hose for heavy or
bulky material. Powered by 1½ horsepower
Universal motor which is detachable for use
as blower, sprayer, or "strap-hak vacuum."
Handy, exceptionally efficient. Free demon-
stration in your plant.



Model 515

Twin Motor Vacuum Cleaner

Economical twin motor vacuum fits any 55
gallon drum—when drum is filled, just
transfer unit to empty drum. Twin motors
give "extra" power to solve difficult wet and
dry maintenance problems—metal and wood
chips, oil sludge, furnace cleaning, etc. Unit
may be used with single motor while other
motor is used as a portable blower, sprayer,
or vacuum cleaner. For 1½", 2" and 3"
hose.



Model 655

Over 50 Hild Floor Machines and
vacuum cleaners available.

There must be one for your job

Write for a **FREE** demonstration

HILD FLOOR MACHINE CO., Dept. MH-957
1217 W. Washington Blvd., Chicago 7, Ill.

Please send me more information on:

☐ Model 404 ☐ Model E ☐ Model 515 ☐ Model 655

Name, Title _____

Company or Organization _____

Address _____

City _____ Zone _____ State _____

WHAT'S NEW

Shroud-pac

THE COMPLETE PACKAGE FOR HANDLING THE DECEASED

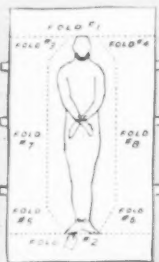
SHROUDPAC, the time-saving procedure for easier, cleaner, faster handling of the deceased. Special hospital white, fully opaque plastic shroud sheet respectfully shields the body from view and prevents embarrassing soilage. Always ready for instant use, no searching, no improvising. SHROUDPAC stores compactly in a handy six-unit dispenser.

For further information and samples, contact your SHROUDPAC distributor. (See below).

SHROUDPAC CONTAINS

these necessary items:
PLASTIC SHROUD SHEET (Adult Size or Child Size) • CHIN STRAP • THREE UNIFORM IDENT. TAGS • TWO CELLULOSE PADS • FIVE TIES

Each SHROUDPAC comes in a polyethylene bag designed to hold the personal belongings of the deceased.



Patton Hall, Inc.

2265 W. ST. PAUL AVE. • CHICAGO 47, ILLINOIS
SHROUDPAC is available through: A. S. Aloe Co.; American Hospital Supply Corp.; E. F. Mahady Co.; Weinecke & Co., Inc.; Physicians and Hospitals Supply Co., Inc.; Will Ross, Inc.; In Canada: Ingram & Bell, Ltd.

HOSPITAL PLAQUES

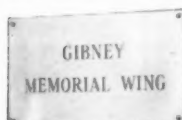
and signs for every purpose in BRONZE and ALUMINUM

THE OPERATING UNIT
OF THIS HOSPITAL WAS GIVEN
IN LOVING MEMORY OF
JOSEPH BROWN WHITEHEAD, JR.
1950

SURPRISINGLY LOW COST

Everlasting beauty. Free design service.

Hospitals from coast to coast have gotten the best for less because of our unsurpassed facilities and years of nationwide experience. It will pay you to look over our new catalog, prepared especially for our increasing clientele in the hospital field. Why not send for it today...now!



Room and Door Plaques
Directional Signs
Dedication Plaques
Memorial Plaques
Building Facade Letters
Plaques to Stimulate Fund Raising

"Bronze Tablet Headquarters"

UNITED STATES BRONZE
SIGN CO., INC.

570 Broadway, Dept. MH, N. Y. 12, N. Y.
Plant at Woodside, L. I.

• A descriptive catalog on the AMF Mobile Lowerator Self-Leveling Dispenser System is now available from the American Machine & Foundry Co., Lowerator Division, 261 Madison Ave., New York 16. The 10-page brochure illustrates and describes the system and includes many photographs of actual installations, showing how Lowerators are filled at the dishwasher and wheeled directly to the desired location for automatic service-level dispensing.

For more details circle #434 on mailing card.

• Industrial Sanitation Counselors, Box 25, Crescent Hill Station, Louisville 6, Ky., have begun publication of two newsletters, "The Supervisor Counselor" for those in charge of cleaning programs, and "The Executive Counselor" for management. They are designed to provide solutions to sanitation problems and contain items on products, methods, publications and events of interest to those in sanitation.

For more details circle #435 on mailing card.

• "Lab-Crest Glassware" is the subject of a new laboratory glass catalog prepared by Fischer & Porter Co., 10 Jacksonville Rd., Hatboro, Pa. Catalog 80C100 describes the line fabricated from Pyrex brand glass, including burettes, aspirator bottles, gas collecting tubes, Karl Fischer apparatus, separatory funnels, nitrometers, manifolds and stopcocks.

For more details circle #436 on mailing card.

• "The Meti-Steroids in Rheumatoid Arthritis" is the title of a new 16mm color motion picture produced by the Schering Corp., Audio-Visual Dept., Bloomfield, N.J. It reviews the chemistry, physiology and clinical application of the new "Meti" steroid hormones and presents the most commonly accepted theories of adrenal corticosteroid therapy and reflects the current knowledge of the subject.

For more details circle #437 on mailing card.

Book Announcements

Creighton, "Law Every Nurse Should Know," 197 pp., \$3.50. Davis and Sheckler, "DeLee's Obstetrics for Nurses," 16th ed., 625 pp., \$6. Krause, "Nutrition and Diet Therapy In Relation to Nursing," 2nd ed., 621 pp., \$6. Sellev and Furfey, "Sociology and Its Use in Nursing Service," 4th ed., 502 pp., \$5. Sollman, "A Manual of Pharmacology," 8th ed., 1535 pp., \$20. Williams and Worthingham, "Therapeutic Exercise," 127 pp., \$3.50. W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.

For more details circle #438 on mailing card.

Suppliers' News

Professional Tape Company, Inc., manufacturer of hospital and laboratory self-adhering specialty labels, announces removal to new offices and plant at 355 E. Burlington Ave., Riverside, Ill., as of September 15.

East-West TV Network, 2924 Auburn Ave., Toledo 6, Ohio, manufacturer of equipment and facilities for closed-circuit television and large screen projection equipment, announces the purchase of the assets, manufacturing equipment and designs held by The Fleetwood Corporation of Florida.

Garden City Plating & Mfg. Co., 1750 N. Ashland Ave., Chicago 22, manufacturer of institutional and commercial lighting fixtures, store fixtures and display and cabinet hardware, announces the purchase of a modern one-story plant at 2501 N. Elston Ave., Chicago, to house its Garco Lighting Division.

MacGregor Instrument Company, Needham, Mass., manufacturer of the VIM line of hypodermic needles and syringes, announces sale of its business and assets to American Cyanamid Company, according to a release recently received. Cyanamid manufactures surgical specialties and Davis & Geck sutures, ligatures and suture needle combinations in addition to other products, and conducts research in and produces a broad line of diversified items.

Johnson & Johnson, New Brunswick, N.J., manufacturer of surgical dressings, announces the opening of the new Eastern Surgical Dressings Plant in North Brunswick, N.J., five miles south of the home office. Comprised of three major buildings linked together by smaller units containing offices and laboratories, the plant employs every possible electronic device for efficiency of operation. It was designed and built by Walter Kidde Constructors, Inc., and will turn out nearly 100 medical products, ranging from baby oil to colored plaster of paris bandages. The plant was designed with further expansion in mind and the three major buildings can be enlarged in a total of six directions without disturbing present machinery installations.

Charles Pfizer Co., Inc., 630 Flushing Ave., Brooklyn 6, N.Y., manufacturer of pharmaceuticals, announces change of name of Sigmamycin brand of oleandomycin tetracycline, potentiated multi-spectrum antibiotic formulation to Signemycin. The announcement states that the name is being changed to eliminate any possibility of confusion with other therapeutic agents.

Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis., national distributor of hospital and sanatorium supplies, announces the opening of an office and warehouse for the Twin City area at 808 14th Ave. S.E., Minneapolis, Minn. The complete line of hospital merchandise will be available at the new location.

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372	Jet Humidifier Ohio Chemical & Surgical Equipment Co.
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